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I am submitting herewith a dissertation written by Donnie Gene Mitchell entitled "Health Education Needs of Tennessee Public Secondary School Students as Perceived by Tennessee Legislators, State Board of Education Members, and School Board Chairpersons." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Education, with a major in Health Education.

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HEALTH EDUCATION NEEDS OF TENNESSEE PUBLIC SECONDARY SCHOOL
STUDENTS AS PERCEIVED BY TENNESSEE LEGISLATORS,
STATE BOARD OF EDUCATION MEMBERS, AND
SCHOOL BOARD CHAIRPERSONS

A Dissertation
Presented for the
Doctor of Education
Degree
The University of Tennessee, Knoxville

Donnie Gene Mitchell

June 1982

3060884

ACKNOWLEDGEMENTS

There are several people that I must acknowledge for their involvement and contributions in this study. I shall always feel indebted to these people, not only for their invaluable contributions, but also for their encouragement.

First of all, a very special note of gratitude goes to all of the professors whom I had in the doctoral program at this University. They have always been willing to take time to help me in my coursework and personal life. The professors have set examples of dedication, encouraged my pursuing knowledge and creativity, and provided this student with an attitude of positivism.

During the course of this study, Dr. Bill Wallace, Dr. Charles Hamilton, Dr. Warren Huffman, and Dr. Dean Champion provided guidance and inspiration toward completing the project. They talk with pride about their students who have graduated, and this motivated me to be one of their graduates. They speak, act, and teach confidence, and thus instilled confidence in me. Although it has been a while since they have graduated from a university, they understand and are compassionate with students. I feel they have put my welfare and interest first. You are most caring!

I am very much appreciative of the Honorable J.B. Shockley, Representative of the Third District in Tennessee for being candid with me in discussion of this project and in his helping to improve the opinionnaire. Dr. O.S. Sexton,

Mr. William Thompson, Mrs. Sandy Smith, and Mr. Frank Holder are school board members who were most helpful in the pretest of the opinionnaire. I am grateful to Representative Frank Lashlee, Chairman of the Education Committee, who endorsed this project.

Dr. Wayne Wylie, former colleague and good friend, was of great assistance in helping me with the programming and statistical aspects of the study. He was a catalyst for me to complete this study.

Mr. Charlie Hobbs, Professor in the Carson-Neuman College English Department and Mrs. R.M. Burts unselfishly devoted their valuable time to help me by their proof-reading this dissertation. For that I am grateful.

A special thank you is given to those legislators, members of the State Board of Education, and local school board chairpersons who participated in this study. They must received dozens of questionnaires throughout the year. Their willingness to respond to the opinionnaire reflects their interest in bettering not only health education, but also exemplifies their concern to seek improvement in Tennessee.

Candy Marek spent many long hours in the tedious and tiring work of typing this dissertation. I am impressed with the excellent work she did and appreciate her helping me.

I have made many sacrifices by undertaking this study.

Sacrifices of time, travel, money, and emotional upheavals are part of the commitment in graduate studies. However, my family has made even greater sacrifices than I. They have been tolerant, patient, and "gone the extra mile with me." Thank you for understanding.

Finally, this study has made me more aware that people are willing to give of their talents and time without expecting anything in return. All the people of whom I asked for help gave unselfishly and cheerfully. This is what life is all about and I shall follow their examples in giving throughout my life. This seems to be the best and true way to express my deep appreciation.

ABSTRACT

The purpose of this study was to analyze and assess the health education needs of students in the public secondary schools of Tennessee as perceived by the legislators, State Board of Education members, and local school board chairpersons in Tennessee. To accomplish this purpose the study was designed to answer six specific research questions.

An opinionnaire was designed for use in this study and formulated by a jury comprised of four University professionals (three of which were in the health field), two legislators, and four local school board members. The final opinionnaire consisted of 46 items which were categorized in six sections that addressed socio-demographic information, school health education content areas, health services, health practices, fiscal matters related to health services and health practices. The instrument was mailed to all of the legislators, all of the State Board of Education members, and all of the local secondary school board chairpersons in Tennessee.

Two mailings yielded a response rate of 40 percent in which 106 opinionnaires were selected for use in the study. In addition to simple response percentages, the statistical procedures of Kendall's coefficient of concordance, Spearman's rank correlation coefficient, and chi-square were used in the analysis of the data.

The findings of this study as perceived by the

respondents were as follows:

1. There were no differences among the Tennessee legislators, members of the State Board of Education, and local school board chairpersons toward health content, services, and practices.
2. Regardless of the salient variables of age, sex, residence, political experience, education, and political party affiliation categories, respondents did not perceive health content, services, or practices differently.
3. Health content areas of first aid, food/nutrition, and physical/dental health were perceived as most important by all respondents, and death education, sex education, and marriage/parenting were perceived as least important.
4. Establishment of a health committee and providing a nursing service were perceived as most important, and least important were providing free school lunches and free physician care by most respondents.

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CHAPTER I

INTRODUCTION

I. THE PROBLEM

The quality of health education in the classroom varies greatly throughout the United States. A number of factors have contributed to these inconsistencies: lack of governmental and community support, lack of research, and the lack of effective evaluation. These factors have contributed a slowing effect on the implementation of a comprehensive program that could provide the nation's 60 million school children adequate health education.

Tennessee has been no different from the rest of the United States in these respects (31). Studies by Huntsinger (45), Orr (76), Hamrick (37), and Pressly (83) have reported a number of inconsistencies and weaknesses in Tennessee's health education program. An inadequate amount of time is allocated for instruction. Content, as well as the teaching approach and instructional method, may differ in each school district. Qualifications for teachers vary. The Tennessee school health curriculum guide is over 20 years old and is virtually unavailable to teachers.

Over the past 15 years the public secondary schools have been subject to intense and diverse cross-pressures. There have been demands by some organizations to include various topics in the school health course of study. Thus,

the public school teacher has often been expected to squeeze into an already crowded time frame--usually one semester in secondary school and two semesters in junior high school--information on heart disease, cancer, sex education, substance abuse, smoking, studies on the problem of dying, and consumer education. Obviously there is little room even for the most cursory examination of any of these topics in such a restricted time span (45).

II. NEED FOR THE STUDY

If educational planning is to meet today's health education needs effectively, it must assume new and added dimensions. Educational planning should be directed toward long-range rather than immediate and haphazard goals, and must be coordinated with all areas of study into a comprehensive program. There have been a number of research studies conducted in Tennessee concerning the school health education program. In 1965 Orr conducted a study of health content reflected in the needs, concerns, and problems as identified by students, parents, and physicians in Knoxville. Huntsinger, in 1971, appraised the health instructional program in the public school, grades 1-12, as viewed by the health teachers (76). In 1973 Hamrick studied the school health program of Shelbyville in terms of instructional practices, status of students' health knowledge, attitudes and behavior, student health interests, and community

perceptions of local health problems (37). Most recently (1978) Pressly surveyed the health instructional practices ascertained by school superintendents (83). In summary, the school health instructional program, health knowledge, attitudes, practices, health interests and needs have been studied extensively using student, parent, physician, teacher, principal, and superintendent populations. However, the Tennessee legislators, State Board of Education members, and local school board chairpersons have been neglected populations who are also influential determinants of the school health instructional program. These policymakers are the persons who mandate standards for all education programs. And, according to the historical development of the school health education as described by the Tennessee Code Annotated, it is recognized that health education in Tennessee has not been planned, but has been developed with the assistance of pressure groups in a disjointed way (105-112).

Hearn, in his research "Public Educational Changes Through Legislation, 1935-1939," reported educational legislation in Tennessee has, at one time or another, included most phases of public education. Legislation was particularly specific and comprehensive prior to 1945. Since 1945 the legislature has delegated more and more policymaking authority to the State Board of Education and local boards of education. The legislatures, from time to time, have enacted laws that were redundant and unnecessary as a result of not being sufficiently aware of existing educational laws.

Because much educational legislation in Tennessee has been general, the specific interpretation, application, and enforcement of the legislation has been delegated to other groups or agencies (1, 42, 78).

School services including health, welfare, and special education for pupils in Tennessee have been steadily extended as the result of the efforts of the State Board of Education in promoting these services. During the period of 1955-1959, the State's education program was reported being more coordinated when compared to other developmental times. The program of instruction and inservice education have both improved steadily during the past four decades. The State Board of Education, through its rules and regulations, continues to provide the framework for the operation of the schools. In summary, the educational laws have been numerous throughout the State's history and the success of the State's program of education in the future may depend upon how well the laws are interpreted and administered by the different school agencies and citizen groups (42).

Although state legislatures play a central part in educational decision-making, there is little research on their involvement in school health education. There are a number of reasons for choosing to emphasize the perceptions of state legislators. The constitutional position of public education in itself warrants focusing on the state legislature. Education is primarily a state function which is administered

locally. The state provides the legal context in which local public school systems operate. In addition, the state is an important source of monies for local schools. State legislators also deal with numerous other matters of immediate consequences to education. In many states, the legislature sets the basic guidelines on teachers' tenure, salaries, deals with questions of curriculum, hiring and certification, special program facilities, and numerous other matters.

School districts have no original powers, but only those delegated to them by the state. It is in the legislature that the basic educational policy is created, and financial systems, appropriations, and controls are enacted. However, the State Board of Education was created by legislation and charged with the responsibility of developing specific education policy complementary to the basic policy enacted by the state legislature. In a general sense, the state legislature creates the educational programs and local school districts operate them. In essence, when the state delegates power to school districts, the state limits the action of the system to what it must do, what it may do, and spells out what it may not do. The school board is restricted by state legislation, and thus, it is apparent that the nature of the local school district responsibility and authority is essentially implementative (62).

According to the studies that have been reported in Tennessee, health education has been one of the most neglected

areas of instruction in the public schools. There has been a lack of local and State direction and motivation to develop a comprehensive health curriculum in response to student health needs and interests. The need for the study developed from the recognition that assessment of educational needs as perceived by students, teachers, principals, superintendents, physicians, parents, etc., influence what and how health education is taught in schools. However, it is the legislators, State School Board members, and local school board members who determine the school health education policies with the assistance of pressure groups. Thus, extensive and thorough determination of the educational needs, as perceived by these policymakers, and evaluation of factors associated with those needs, will assist in more complete planning for the future of health education in Tennessee.

III. PURPOSE OF THE STUDY

The purpose of this study was to analyze and assess the need for health education experiences of students in the public secondary schools of Tennessee as perceived by the legislators, State Board of Education members, and local school board chairpersons in Tennessee.

IV. STATEMENT OF THE PROBLEM

The following are questions to which this research was directed:

1. What are the health education needs of students in the Tennessee public secondary schools as perceived by legislators, State Board of Education members, and local school board chairpersons?
2. Is there a difference in the needs as perceived by the Tennessee legislators and as perceived by the State Board of Education members and as perceived by the local school board chairpersons?
3. What areas of the school health education program are these policymakers in agreement and disagreement?
4. What issues of the school health education program do policymakers perceive as most important and least important?
5. What needs in school health education do policymakers perceive as favorable and unfavorable?
6. Is there a relationship between what the policymakers perceive as student health education needs and related characteristics such as age, sex, education, years of political experience, political affiliation, or residence?

V. BASIC ASSUMPTIONS

The following basic assumptions were considered essential for this study:

1. The Tennessee school board chairpersons' perceptions of student health education needs was suggestive of

needs as perceived by fellow school board members who have helped elect them to the position of leadership.

2. The health education needs of students of the secondary schools as perceived by the policymakers could be determined by means of a prepared inventory.
3. For the purpose of this study it was assumed that the responses made were honest and accurate.
4. The legislators, State Board of Education members, and local school board chairpersons chosen for inclusion in the study will be sufficiently cognizant of the school health education program to make an appropriate response to the inventory used in the study.
5. Health education needs of students as perceived by legislators, State Board of Education members, and local school board chairpersons, in regard to the inventory, were measurable.
6. The instrument used in this study was appropriate for determining health education needs of Tennessee public secondary school students as perceived by the Tennessee legislators, State Board of Education members, and school board chairpersons.

VI. DELIMITATIONS OF THE STUDY

1. The study was restricted to legislators, State Board of Education members, and local school board chairpersons in Tennessee.
2. All Tennessee legislators were asked to participate, but only those who completed the inventories were included in the study.
3. All Tennessee State Board of Education members were asked to participate, but only those who completed the inventories were included in the study.
4. All local school board chairpersons of Tennessee were asked to participate, but only those who completed the inventories were included in the study.
5. Only subjects completing the inventories in the allotted time frame of four weeks were utilized in the study.

VII. DEFINITIONS OF TERMS

The following terms were defined as they relate to this study:

1. Health--state of complete mental, physical, and social well-being, not merely the absence of disease or infirmity (WHO).
2. Health education--the instruction of providing learning opportunities which favorably influence

- understanding, attitudes, and practices in regard to individual and community well-being (AAHPERD).
3. Health education need--that which is necessary or desirable to maintain or improve physical, mental, and emotional well-being of all students (AAHPERD).
 4. Policymakers--legislators, State school board members, and school board chairpersons who decide what content areas are taught, classroom time, teacher requirements, and budget for school health taught in the public secondary schools.
 5. Health education program--includes all health instruction, health services, and health practices in the public school settings.

VIII. ORGANIZATION OF THE STUDY

Chapter I of this study includes an introduction, need for the study, purpose of the study, statement of the problem, delimitations, limitations, basic assumptions, definitions of terms, and organization of the study. A survey of literature related to school health education studies in the United States, school health education studies in Tennessee, school health education legislation in Tennessee, and studies related to methodology are presented in Chapter II. An explanation of the methods and procedures utilized in this study are presented in Chapter III. Chapter IV presents the analyses and interpretation of the data collected in the

study. A summary, conclusions, and recommendations for future studies are provided in Chapter V. Chapter VI consists of an epilogue to the study.

CHAPTER II

REVIEW OF LITERATURE

I. INTRODUCTION

The major purpose of this study was to investigate the health education needs of students in Tennessee public secondary schools as perceived by all the legislators, State Board of Education members, and local school board chairpersons of Tennessee. The researcher examined school health education studies in the United States, school health education studies specifically in Tennessee, historical development of Tennessee legislation with regard to the school health program, and studies related to methodology.

II. SCHOOL HEALTH EDUCATION STUDIES IN THE UNITED STATES

In recent years it has become apparent that Americans have begun to place greater value on the importance of health than in the past. This transition in the relative worth of health to individuals in our society has been reflected by the increasing importance of health education. During the past decade, greater financial aid has been authorized to support the implementation and maintenance of health education programs at the federal, state, and local levels. As a consequence, health education has become an integral part of many public school curricula as well as a basic function of official and voluntary agencies (95).

In many school systems where there are no organized health education programs, there is a tendency to develop fragmented programs. Generated by social concerns over the health behavior of the young, bits and pieces of the health education curriculum are being inserted into the curriculum in a poorly planned fashion. This practice is observed with alarm by some health educators, while others consider it at the least a "foot-in-the-door" to the total curriculum. "It is conjectured that fruitful investigation of one aspect of health education may lead to further exploration of other aspects leading eventually to a complete program" (100). In many instances, this viewpoint has been justified. Programs begun at the secondary level have filtered down to the elementary level. Conversely, programs initiated at the lower level have been continued later at the secondary level. Alcohol, drug abuse, smoking, safety, sex, and venereal disease education are among the components most frequently singled out for concentrated attention at one time or another. These areas have been perceived as problems by influential individuals and groups at the local, state, and national levels. Means has briefly traced factors influencing the health education curriculum over the past 170 years. Textbooks, courses of study, education subsidized and mandated by legislation, and negative pressures exerted by various health and/or education-oriented groups are factors that seem to have had an abiding influence on the health

education curriculum throughout the years (63).

Several state studies to determine practices in health instruction have been conducted, with some done prior to the School Health Education Study, Inc., and some as a result of it. In 1952, Dratz took a survey of health education in public secondary schools of six selected states: California, Florida, Iowa, Michigan, Montana, and New Jersey. This study indicated that none of the states surveyed, except New Jersey, offered a separate course in health instruction (23).

Febel, in 1954, made a study of 250 mothers to determine their perception of health content needs for students at the secondary school level in Buffalo, New York. Febel used the interview checklist consisting of 24 content areas with a Likert Scale as a method of collecting data. Some of Febel's conclusions were as follows:

1. The mothers' religious preference did not affect their opinions of what should be emphasized in school health education.
2. None of the health areas taught received an unfavorable response (27).

In 1956, Sinacore studied the health education programs in the public secondary schools of Long Island, New York, using the following nine areas for evaluation: administration, community resources, coordination of programs, course content, facilities and equipment, methodology, needs and

interests, teacher preparation, and time allotment. From the study he concluded that personnel were unqualified according to state standards, time allotment was inadequate, the relationships of biology to health education and physical education were confused, and that only a small number of schools attempted correlation of any kind in health education (98).

The health instruction in public secondary schools in 32 states was evaluated by Manthey, in 1962, as a base for improvement of health instruction in schools of Lincoln, Nebraska. Findings indicated that in these states formal courses in grades 10 and 11, with 55 minute periods per week for one semester, was the general practice; that physical educators were the ones teaching the class; that the lecture-discussion method was the one most often used; and most of the evaluation was done through teacher-constructed tests. Recommendations from this study included the following: health education should be coordinated at all grade levels, periodic studies should determine content and desired outcomes of health courses, philosophy of health education should be in the curriculum guide, and the teacher of health instruction should possess a major in health education (59).

An article published in 1963 by the National Educational Association, "Deciding What to Teach," pointed out that pressures were exerted on the schools to prepare children in many areas heretofore considered the responsibilities of

home, church, and other segments of the community (20). The pressures arose partly because changing patterns of family and community life diminished the amount of informal, out-of-school education in such areas as health, homemaking, recreation, and vocational preparation. "They arose also because conditions of urban living made it increasingly imperative both for society and for the individual, that all children learn ways of living safely and healthfully, making wise consumer choices, using leisure time positively, and practicing constructive citizenship" (20). Pressures to make course changes and additions have come from agencies, organizations, parents, and partisan groups (20).

Even though the extent of the impact made by the School Health Education Study, Inc. (in 1961-1963) on specific curriculum revision cannot at this time be fully realized, its influence can be noted throughout the literature and in our professional preparation institutions. This study was an attempt to investigate the health education practices of public schools in the United States. The researchers found that time allocated for health instruction varied, as did requirements, content, and teaching practices (100).

Kennison reported, in 1965, from his study of Kentucky's public schools that the typical Kentucky school had a year's health course at the ninth grade level using a two-three plan alternating with physical education and reversing the two and three each semester. The typical class was 55 minutes

in length and contained content designed by the teacher. He recommended an attempt be made to achieve a balance in the health instruction program and that similar research be repeated in a few years (51).

Impetus for more localized research has already been gained through the recommendations of this very important study. A discussion of some of the specific state studies adds evidence to this fact. In a study (1969) of health instructional practices of the public secondary schools of New Jersey, Levy recommended new State requirements with a minimum of one semester of health education, five days per week, in the seventh, ninth, tenth, and twelfth grades; health specialists to teach classes; and classes to be made co-educational.

The Rhode Island School Health Education Study (1969) was an extensive State study for the purpose of establishing a baseline for future planning and curriculum development. The findings were not dissimilar to the National Study--1) State support for health education in Rhode Island was weak, 2) there was little uniformity in course titles or content, 3) the responsibility for curriculum decision rested with individual teachers, and 4) the time allocation for health instruction varied. The study did reveal that educators in the State had a keen perception of the problems in health education; thus, they could themselves provide suggestions for improvement of the status of health education in Rhode Island (113).

In a study of grades 1-12 in the Kansas public schools (1971), Dorsch found that health education in secondary schools was taught by a teacher who either was not a specialist or who had a dual major. Responses indicated that secondary school students were less enthusiastic about health education than were elementary students. Recommendations included requiring health education at both junior and senior high school levels and making mandatory at least four courses in health education for every prospective teacher (21).

President Nixon, in 1971, created the Committee on Health Education for the following purposes: 1) to assess what was being done in health education, 2) to evaluate the effectiveness of that effort, 3) to recommend the health education approach, and 4) to devise a strategy to implement whatever was recommended. Nothing happened with the report from the Committee on Health Education because President Nixon left office during this report and no one pursued the matter.

A study to evaluate the policies and procedures relating to the major divisions of school health (which include instruction, environment, and services) was made by Lasch in 1972. With an 80 percent return (representing 40 of 50 states), Lasch concluded there was a lack of definite policies and procedures in school health (54).

A recent investigation (in 1976) of state school health programs in the United States was made by Castile and

Jerrick. School health consultants or state commissioners of education/health responded as follows:

1. Three states made no provisions for any health education at the state level.
2. Twenty-nine states certify teachers of health education with 10 of these states offering dual certification in health and physical education.
3. Safety education is mandated in 16 states, mental health in 13, personal health in 10, community health in 10, family life-sex education in eight, anatomy and physiology in five, and 16 states mandated comprehensive school health education.
4. Alcohol, drugs, and tobacco instruction are the subjects most frequently required by state legislation (9).

There are many other related studies whose writers advocate change in the school health instructional program. These changes include the following: 1) make the material relevant for application, involve parents, revise curriculums, and allocate more time (76); 2) question some basic values and standards; (4); 3) make content and time consistent; 4) provide health education consultant for teachers' inservice training and on-site assistance; 5) utilize the National Health Test (59); 6) health curriculum should focus on life-centered concerns taking into account environmental influences and cultural values (13); 7) make health education a more

personal and applied subject in which students can tailor it to change specific behaviors and address specific needs (4); 8) curriculum should not be so crisis-oriented but designed to cover the field (101); and 9) teaching youth should be a combination of what they want to know and what they should know about health (8).

In summary, the studies of state programs reveal the need for much improvement and for further study of the specific areas of health instruction. However, they also reveal an interest and re-awakening on the part of health educators in bringing health education up to a level with other courses--not for competitive purposes, but because of a basic belief in the inherent value of this kind of behavior that can be learned effectively through adequate health instruction.

There are a number of deficiencies that have been identified as well as a number of recommendations presented that would enhance the quality of health education in the public schools. Of these recommendations, one of the most recognizable deficiencies that could be addressed is that of requiring students to experience the health education course for a minimum of 50 minutes per day, five days per week, two full semesters in junior and senior high schools. This requirement would be made possible through state legislation.

This section of the chapter is devoted to the studies related to this study in content. The review of literature

related to content provided insight as to the national trend with regard to the status of health instruction. It should be noted from this section that in the studies presented thus far, the findings have been similar from state to state.

III. SCHOOL HEALTH EDUCATION STUDIES IN TENNESSEE

The second content area of study focuses on the school health education studies that have been conducted in Tennessee.

Orr evaluated the health interests and needs for the purpose of determining health content in secondary schools. Students, parents, teachers, and physicians were surveyed in Knoxville using a 10 percent random sample. Findings indicated health interests and health needs varied with each group (76).

In Tennessee (1971), Huntsinger appraised the health instruction program in public school, grades 1-12. He found the following:

1. Instructional time varied with regard to required minutes per period, periods per week, and semesters per year.
2. Teachers of health at the elementary school level were usually certified elementary school teachers, and health teachers at the junior and senior high school level were most often physical educators.
3. The three most common resources used in the

determination of course content of health classes were health textbooks, individual teacher decision needs, interests, and problems.

4. Many content areas that needed to be emphasized at various grade levels were not taught at all.
5. Many content areas that were emphasized at the elementary school level were also emphasized at the junior and senior high school level.
6. The prevailing practice was to require health in each of the elementary grades, two semesters of junior high school, and one semester of senior high school.

The research concluded that not enough instructional time was allowed for teaching health courses in any of the three grade levels. He further contended that many of the school districts did not meet the state requirements concerning health education. Huntsinger made three significant recommendations:

1. A Statewide committee should be organized to develop a State curriculum in health education.
2. State health instructional time required should be stated in minutes per period, periods per week, and semesters per year for all grade levels.
3. The State requirement of health at the high school level should be changed from one semester to two semesters (45).

Adams, in 1973, appraised the health instruction programs in Tennessee's public secondary schools by determining: 1) status of health instruction, 2) health knowledge of twelfth grade students, 3) relationship between selected items of health instruction status and the results of the health knowledge test, and 4) opinions of secondary school educators pertaining to improvements needed in health instruction including suggestions for implementing the recommendations. The random sample was comprised of principals, teachers, and senior high school students. The findings were as follows: 1) Tennessee's twelfth graders exceeded the norms on the Seffrin Health Knowledge Test, 2) health education is required for graduation, and 3) time for health instruction is equal to time allotted to other subjects taught on a semester basis. The conclusions included the following:

1. Planning for health education appears to be a great concern for health teachers.
2. Inservice opportunities are lacking or limited.
3. There is a lack of community and student involvement in planning for health education.
4. There is a failure to maintain current materials for health instruction.
5. There is no clear distinction between health and physical education.
6. Coordination of health education with community resources is lacking.

Another study relative to Tennessee was conducted by Hamrick (37) (1973), "A Comprehensive Evaluation of the School Health Program in Bedford County, Tennessee." He studied the school health instructional practices as determined by principals, the status of students' health knowledge, attitudes, and behavior as revealed by standardized health behavior inventories, students' health interests, and community perceptions of local health problems. The conclusions of the study were:

1. There was no indication of a sequential plan of health education opportunities for grades 1-12.
2. Health knowledge of Bedford County students was low when compared to national norms.
3. Students evaluated the health course and were particularly interested in the areas of sex education, mental health, social-emotional health, and drug abuse.
4. The overall research design of the study proved to be functional for rendering a thorough and comprehensive assessment of the school health education program and for providing information useful for curriculum development.

Pressly initiated an investigation in 1978 for the two-fold purposes of determining the status of health instruction in Tennessee public schools and to provide recommendations toward upgrading the Statewide health curriculum guide. Two

groups included in the study were the school superintendents from each of the 147 school districts in Tennessee and junior high and senior high students. School superintendents were to ascertain the health instructional practices and students responded to health knowledge tests. The following conclusions were based on the findings of the study: 1) instructional time was inadequate, 2) the teaching of health by incidental methods was indicative of a lack of planning, 3) health content was determined by haphazard means, 4) there was a lack of coordination of the health education program throughout all grade levels, 5) controversial subject matter was inadequately presented in appropriate grade levels, 6) there was a lack of materials, time, and qualified personnel, and 7) there was parental and community resistance to health teaching (83).

IV. SCHOOL HEALTH EDUCATION LEGISLATION IN TENNESSEE

The third content area of study focuses on school health education legislation in Tennessee. An historical perspective was chosen so as to examine the development of legislation of health education and related school health and safety directives. An attempt to legislate "Practice, Prevention and Hygiene" can be noted in 1873 with Tennessee Code Annotated (TCA) 5508.

The keeper (of a penitentiary) shall cause the prisoners to wash themselves every morning, and immediately before meals, and the males have their beards shaved as often as may be necessary; the cells to be swept every

every morning, and fumigated, during the summer and fall season, once a week, or oftener, with some disinfecting substance; to adopt such other measures as may be recommended by the physician, or the board of inspectors, to promote neatness and health (103).

In 1896, TCA 1401-1458 required two particular studies to be included in public schools--"physiology and hygiene," and TCA 1487 (1a) specified "adopted textbooks shall be used for a period of five years" (103).

Physiology and hygiene, with special reference to the nature of alcoholic drinks and narcotics and smoking cigarettes, and their effects upon the human system, shall be taught as thoroughly as other required branches, and shall be made a regular course of study for all pupils in all schools supported entirely or in part by public dollars (103).

These laws were reflective of the times and values of people during that period. Furthermore, the prohibition movement of 1895 may have resulted in TCA 1456.

No certificate shall be granted to any person to teach in the public schools of this state who has not passed a satisfactory examination in physiology and hygiene, with special reference to the effect of alcoholic drinks and narcotics and cigarette smoking upon the human system (103).

A decision to specify "hygiene and sanitation" in every elementary city school during 1917 (TCA 1487) reflected the importance of initiating health education at an early age (103). As early as 1932 (TCA 2418), legislators apparently were convinced of a relationship between health and physical education by stating:

Physical education is to be prescribed and taught--all pupils, of both sexes, in all the elementary and secondary public schools shall receive as part of their prescribed course of instruction . . . and shall occupy periods totaling as many minutes each day and as many

hours each week throughout each and every school term as may be determined by said board (103).

Safety practices were expanded in that same year "to give at least two fire drills each month during the term" (TCA 2343) (111). Emphasis on preventive health measures was presented (in TCA 2326) in which "examination for communicable disease is required of school children," and (in TCA 5763) the "Department of Public Health shall appoint a director to instruct the pupils of the public schools and inmates of charitable institutions in the importance of the care and preservation of the teeth and lecture to the teachers." And the ethics of teachers were described (TCA 2353) as being of "good moral character, and not addicted to intoxicants or narcotics and shall not receive a certificate to teach unless he has a good moral character" (111).

Environmental conditions became emphasized in 1934 in which "tours of inspection and survey among the public schools throughout the State would be made periodically" (TCA 2314) and (TCA 2339) dealt with safety precautions in which it was "unlawful to keep doors and windows locked--it would prevent the egress of pupils in case of fire or other emergency." TCA 2423 added another content area to be included as part of hygiene--"the art of safety" (112). In 1938, the "art of safety" to be taught was spelled out in detail:

It shall be the duty of principals and teachers therein, to instruct pupils in the art of safety as against injury on the public thoroughfares, highways, and

streets of the state, and other places where said students may come in contact with, or be in danger of bodily injury, for at least 15 minutes in each week during the time said school is in session (112) (TCA 2423).

The Commissioner for the Department of Public Health in 1938 was given the responsibility (in TCA 5764) to "distribute (dental) literature throughout the state as well as inform the people in the proper way to care for the teeth."

It should be noted that "A Report of the Work of the State Conference on Public Education for School Superintendents, Principals, Supervisors, and Teachers" was held at The University of Tennessee in July, 1947, and concluded that "the people of Tennessee are convinced that health instruction should be an integral part of the school program and that it should be given a place of importance equal to that usually occupied by the conventional subjects" (79).

Later, in 1950, TCA 2355 required 27 quarter hours in education and 18 quarter hours a subject in order to receive a teacher's certificate and to teach a subject (112). One of the more important pieces of legislation was approved in 1951 which would:

. . . empower the State Board of Education to prescribe rules and regulations for approval and classification of public schools, make regulations for their government, prescribe curricula and approved courses of study, and to repeal all laws and parts of laws in conflict herewith (Tennessee Public Acts, chapter #119, HB #85) (106).

There has been legislation to:

. . . prohibit and make it unlawful to teach courses in sex education pertaining to homo sapiens in the public

elementary, junior high, or high schools in the State of Tennessee unless the courses are approved by the State Board of Education and the local school board involved and taught by qualified instructors as determined by the local school board involved. This Act shall not apply to general high school courses in biology, physiology, health, physical education, or home economics taught to classes (Tennessee Public Acts 1969, chapter #304, SB #656) (109).

It was suggested that defensive driver education courses should be offered and included in such a curriculum in 1972 (TPA, chapter #607, HB #1206) (109).

Summary of Legislation

An attempt has been made to acquaint the reader with Tennessee legislation as it developed from 1873 to the present day. Legislation has been directed at school health content, practices, teaching ethics, safety, and limitations. The laws reflect both rational and emotional thought; however, one must raise the question--do these health education laws meet the needs of Tennessee public schools today?

V. STUDIES RELATED TO METHODOLOGY

A number of studies have been made to survey policy-makers' perception of educational issues in the past three years. In these studies the population has consisted of legislators, school board members and presidents, and school superintendents. None of the research presented the perspective of decision-making done by State Board of Education members advising the legislature on educational issues, the legislative body executing laws to which the local school

board members implemented those laws. None of the research reviewed used that particular population for study. It should also be noted that a number of educational issues have been studied. These issues include the following: death education, music education, school integration, year-round school, kindergarten, serving handicapped children, graduation requirements, educational accountability, roles, rights, relationships, and responsibilities of personnel, selected school programs and services, and so forth. Again, none of the research examined the secondary school health educational needs of students, per se.

In a study of legislators, Vann (1970) researched the "North Carolina Legislators' Perception of the North Carolina Community College System (NCCCS)." He proposed to determine not only legislators' perception of the NCCCS but also to determine the relationship of selected demographic and ecological factors of the legislators to their perception of philosophy, objectives, programs, and clientele of the NCCCS. The population consisted of a sample of 85 (29 senators and 56 representatives, 58 percent response). Validity of the instrument was determined by two means. First, the instrument was critiqued by three former members of the North Carolina General Assembly. And, secondly, seven graduate students refined the instrument. Personal interviews were conducted in the home town of each legislator by six trained colleagues. Data were then punched on to

cards and the entire statistical analysis (consisting of frequency distributions, percentages, analysis of variance, and correlations) was performed (120).

In another study of legislators (1976) Smith conducted "A Survey of Attitudes Held by the Tennessee General Public and State Legislators Toward Higher Education." Particular emphasis was made on assessing where these groups give priority for expenditures of tax dollars. By means of digit dialing, 533 Tennesseans were selected and interviewed by telephone. Questionnaires were hand delivered to all of the legislators, followed by a letter three weeks later, and 78 legislators responded (59 percent). Nine of sixteen questions on the instrument were presented in the same form to each group, thus providing an opportunity to compare the two by means of the chi-square statistical technique. The remaining questions were designed to determine the extent to which legislators receive input from their constituents on a variety of issues and services, the nature of constituent contacts, and the degree to which legislators have had personal exposure to college and university programs and activities. The survey was supposed to yield the data necessary to form valid conclusions about the status of higher education in Tennessee, its relative priority among the various State services and agencies, and its perceived strengths and weaknesses in the minds of the general public and the political decision-makers. More importantly, it was

anticipated that the results would suggest ways in which higher education might improve its public image, strengthen its relationship with Tennesseans, and enhance its capability to understand and respond to the needs of the State. The data were presented in frequency tables and percentages. The findings suggest that higher education continues to be held in high regard by the great majority of the general public and members of the General Assembly. More than one-half of the respondents in both groups expressed support for increasing State government expenditures for education in general, giving it a second ranking in a list of 10 State services. Forty percent favored increased State financial support, especially for colleges and universities. Nearly 80 percent of legislators supported increased funding for medical and dental schools. Colleges were favored by about a three to one margin over vocational schools. The majority of both groups believe colleges and universities are producing too many graduates for the job market. Ideally, legislative decision-makers elected by the people should reflect the attitudes and sentiments of the citizenry they represent (102).

Cistulli (1977) sought to ascertain the perceptions of legislators, community college advisory council members, administrators, and faculty toward the nature, organization, management, and financing of community services in public two-year colleges. He used chi-square to reveal the

differences among and between the groups. The population was made of a sample composed of all percent of legislators, advisory council members, and administrators, and 20 percent of faculty of public two-year colleges in Connecticut. Cistulli followed three steps in an effort to insure the questionnaire's validity and reliability. First, his committee reviewed and revised the instrument. Secondly, the questionnaire was sent to the National Council of Community Services (which consisted of authorities in the field) in Washington, D.C. to establish the validity of the contents. Once the Council reviewed the questions and their comments incorporated into the questionnaire, the test-retest method was used to establish reliability. The questionnaire was mailed to 15 individuals holding the title of Director or Dean of Community Services in public two-year colleges in New England. Ten days after each questionnaire was returned, the same questionnaire was again mailed to the same individuals. A Phi Correlation Coefficient was computed between the two sets of answers. Questions were considered reliable at .70 and above. Returned questionnaires were examined by both descriptive and statistical techniques. The application of the chi-square test to each question showed the difference among the groups. Statistical significance was sought at the .05 level (16).

In 1977, Walker examined the perceptions of the Louisiana legislature concerning the cooperative extension

service. The questionnaire was hand delivered to the 144 legislators during a legislative session and 79 percent responded. Statistical analysis of the data included chi-square test of independence which examined the relationship between place of residence as selected variables related to the overall extension program. Frequency tables were used to determine differences between legislator's occupation (lawyers and farmers) and selected legislative committee membership and selected dependent variables (125).

Perceptions of parents, teachers, school administrators, and school board members with regard to the roles of the Minnesota elementary schools was examined by Nolin (1977). He sought to determine the perceptions of groups as well as determine differences among and between the perceptions of respondents with regard to the roles of elementary schools. Data were analyzed using the chi-square test of significance with the .05 level of significance difference (75).

In a study to determine the rights of superintendents and principals as perceived by school board members, school administrators, and teachers in Nebraska (1977), Prindle developed his questionnaire from the review of literature and through the utilization of a panel of experts. Comparisons of groups' opinions were made in percentages (84).

A study of Virginia school superintendents and school board chairpersons' perception of the school superintendents' role in collective negotiations was conducted by Hanna (1977).

An attempt was made to determine if variations that appeared between the perceptions of respondents were attributable to differences with respect to age, level of education, length of service, size of school system, type of community, and the interaction effect of those variables. Multiple regression was used to test for the interaction effect as well as the individual and collective effect of the selected independent variables on those perceptions. Collectively, or by their interaction, the five independent variables did not significantly affect the respondents' perceptions. The t-test on means was used to determine if a significant difference between their perceptions existed. Thus, it appears that demographic variables do not appear to be significant factors correlated with educational issues (38).

In 1977, Liddell made a comparison of attitudes toward music education among school board presidents, superintendents, principals, and music teachers in the public schools of Mississippi. Liddell used the Punke Music Education Attitude Scale (Likert-type scale) to measure their attitude toward five specific areas: 1) music's role in school-community relations, 2) role as a discipline of the mind and body, 3) role as a social activity, 4) as an aesthetic experience, and 5) as a leisure-time activity. The hypothesis offered in the study was statistically tested by the multivariate analysis of variance and the univariate analysis of variance. The Scheffe test was used to determine the source

of significance F-ratios among the means. Differences were considered significant at the .05 level. With the increasing emphasis on accountability coupled with the tight-budget minds of today's school board members and legislators, all curricular areas are subject to re-evaluation (especially music and school health education). Thus, Liddell stated it is important that school boards be informed of music education. With threats of financial cuts and competing priorities for the tax dollar, effective communication is a must if school board members are going to see music education as a fundamental, rather than a frill (58).

In a study to determine the attitudes of clergy, school board members, and elementary teachers toward death education being taught in the Ohio public schools (1978), Croskery used a one-way ANOVA to indicate the significant differences. The population consisted of 95 clergy randomly selected and based on the membership of major faiths along national lines. One hundred elementary teachers were drawn from one school system through a random representative manner, and 91 school board members were queried from 17 Ohio communities of every size and section of the State. Thus, a total of 286 were randomly surveyed with a total of 213 (74 percent) responding. The results indicated that all three groups viewed death education in schools negatively. There was no significant difference in the attitudes of the three groups. After some refinement, a pilot study was taken to test the reliability of the

instrument using the Pearson Correlation Coefficients. This study sought to answer questions as to what were the attitudes of the three groups toward death education being taught in school, do the attitudes differ, and were the respondents receptive to an inclusion of death education as part of the elementary school curriculum. The instrument was composed of 18 items. For scoring purposes, a Likert-type scale, ranging from five points (strongly agree) to one point (strongly disagree), was used. Reverse scoring was used when necessary and the highest possible score was 90 (18×5). One-tailed chi-squares were used to compare the sample with the general population or the demographic data (19).

Church, in a study of the Teacher Tenure Act of South Carolina, in 1978, compared three groups (superintendents, selected school board members, and selected principals) to determine their perception. Two statistical procedures used to analyze the questionnaire responses were: 1) frequencies and percents of frequencies for every item from each group and 2) a chi-square statistic was computed on each item common to two or more groups to determine if there were significant differences of opinion among the three groups. Of the 952 questionnaires that were mailed, 75 percent were returned to the researcher. Of these responses, 114 were school superintendents, 374 school board members, and 430 principals were randomly selected to be surveyed. School board members were selected because they are the

representatives of the people and because local board of education is responsible for implementing the state laws pertaining to education and have general control and supervision of all matters pertaining to public schools (15).

The previous studies have focused on the following: 1) populations consisting of two or more groups, 2) issues in the field of education, 3) instrument designs (primarily utilizing the Likert-type scale), and 4) statistical techniques employed in the analysis of data. Demographic data shall be included in this research project and used for descriptive purposes. This research project will examine the relationship between demographic variables and student health education needs as perceived by policymakers to see if a condition may be identified.

VI. SUMMARY

An extensive review of literature was conducted to formulate categorical areas and the criteria important to each of the categories as they relate to the design and management of secondary school health education programs. The review included an examination of professional journals, health education textbooks, Dissertation Abstracts, the Educational Index, the Encyclopedia of Educational Research, and two searches by the Educational Research Information Center (ERIC). Chapter III examined the population, instrument, and statistical procedures utilized in the study.

CHAPTER III

STUDY DESIGN

I. INTRODUCTION

As discussed in the preceding chapter, health educational practices, services, students' knowledge, attitudes, needs, and interests at all grade levels have been surveyed repeatedly in the past 20 years. Many recommendations have been made to improve the school health program. This study attempted to investigate the health educational needs of students in the Tennessee public secondary schools as perceived by the persons who formulate school policy. With this purpose in mind, the fundamental areas of methodological concern of this study were: population of the study, opinionnaire design, administration of the instrument, and collection, organization, and analysis of the data. This chapter deals with these four concerns.

II. THE POPULATION

The population of this study consisted of three groups who determine the local and State policies that govern school health instruction, health services, and environment. At the time of this study, Tennessee legislators were the population who determined the State statutes. The legislature was composed of 97 representatives from the 95 counties and 33 senators. The State Board of Education members represented

the second group in the study, and it was composed of 16 members. The third segment of the population consisted of the local secondary school board chairpersons throughout Tennessee, and numbered 126. Because of the large number of school board members throughout Tennessee, the amount of time available, and the expense of surveying each school board member, it was believed that utilization of every school board chairperson would be somewhat suggestive of the total population of school board members.

All of the legislators of Tennessee were surveyed in this study. The names and addresses of each legislator were obtained from the Tennessee Blue Book 1979-1980 (104). All State Board of Education members' and all school board chairpersons' names and addresses were obtained from the 1978-1979 Directory of Public Schools (105). Selections were made in order that school districts of all sizes, geographical locations, and economic levels would be representative of all school boards.

The next phase of the study involved designing an instrument and selecting a method of administering the instrument.

III. OPINIONNAIRE

A mail opinionnaire was selected as the best means for collecting data concerning health education needs of Tennessee secondary school students as perceived by

legislators, State Board of Education members, and school board chairpersons. The mail opinionnaire allowed legislators, State Board of Education members, and school board chairpersons to answer questions with greater assurance of anonymity than other forms of sample survey.

The major limitation of a mail survey is the difficulty in obtaining an adequate response. In conducting this survey, several tactics were adopted in order to increase return:

1. The opinionnaire was constructed so as to facilitate a minimum effort and time.
2. The instrument was printed on a light yellow paper, a color which has been reported to produce higher returns than other colors (79).
3. The survey had the official backing of both a Democratic and a Republican legislator, encouraging their colleagues and school board members to participate in the study.
4. A cover letter was used in an attempt to overcome any prejudice the recipients might have against responding to this survey (see Appendix A).
5. A pre-addressed, stamped envelope was included in the mailing of the instrument.
6. Even with careful scrutiny and adherence to the other survey tactics, complete returns were not to be expected without reminders to those who did not

at first respond. Thus, postcards were mailed to all of the population to stress the importance of each one's participation (see Appendix A). The follow-up was mailed automatically 10 days after the initial mailing date of the opinionnaire to everyone.

The content of the instrument was constructed in such a way as to obtain both demographic data (i.e., age, sex, marital status, education, political party) and students' health educational needs as perceived by policymakers. In order to provide an opportunity to compare the data of legislators, State Board of Education members, and school board chairpersons, the same instrument was used for each group. The complete opinionnaire is found in Appendix B.

IV. CONSTRUCTION OF THE OPINIONNAIRE

The proposed study necessitated the development of an opinionnaire capable of determining the perceptions of Tennessee policymakers in regard to the health education needs of secondary school students. The instrument was developed with regard to issues and implications of school health education that were ascertained as descriptive of school health education as surveyed by researchers Adams, Hamrick, Huntsinger, Orr, and Pressly.

The first draft of the opinionnaire was the result of a comprehensive review of literature closely related to research

conducted throughout the United States and specifically in Tennessee with regard to school health education. Other review of literature focused on Tennessee laws related to health education and studies related to methodology. The instrument was developed in regard to the issues, course content, and requirements of the school health education program as described in the review of literature and were closely related to the needs of the students. A panel of experts were asked to review the instrument. Those persons included:

Dr. Bill Wallace	Mr. Frank Lashlee
Dr. Warren Huffman	Mr. J.B. Shockley
Dr. Charles Hamilton	Dr. O.S. Sexton
Dr. Kenneth Tanner	Mr. D.S. Smith
Mr. Frank Holder	Mr. William Thompson

Their comments and input in the final format of the instrument were extremely useful. The literature review and the jurors helped to generate research questions regarding the health education needs of secondary school students as perceived by policymakers. The final form of the instrument included revisions based on suggestions submitted to the researcher by the pilot test respondents. The final draft of the opinionnaire consisted of four divisions.

Division I, the eight items found in the division were designed to procure data which were helpful in the treatment of perceptual differences between the three groups of

respondents. The following information was requested:

- 1) political position, 2) age, 3) sex, 4) years of experience, 5) educational level, 6) political affiliation, 7) political philosophy, and 8) locality of residence.

Division II consisted of eight items used to ascertain the perception of respondents toward school health services that best meet the needs of students.

Division III consisted of 13 items used to ascertain the perception of respondents toward school health instructional practices that best meet the needs of secondary school students.

Division IV consisted of 19 items used to ascertain the perception of respondents toward possible content areas of school health that best meet the needs of secondary school students in Tennessee.

Divisions II, III, and IV were constructed on the basis of the Likert-type scale which gave the respondents a choice between 1) strongly agree, 2) agree, 3) undecided, 4) disagree, and 5) strongly disagree in their responses. The Likert-type scale was selected for use due to its proven accuracy and efficiency in retrieving data. An important study concerned with the use of scales was done by Tittle and Hall. They compared the effectiveness of various types of attitude scales (Likert, Guttman, Semantic Differential, Thurstone, and Self-Rating) in predicting indices of voting behavior. The Likert scale was superior to all other scale

types; it yielded a mean correlation coefficient of .54 with the objective indices of voting.

When agreement was reached between the investigator and his committee regarding the opinionnaire, one other step was followed to insure its reliability. The test-retest method was used by mailing the instrument to two legislators and four school board members. Ten days after the opinionnaire was returned, the same instrument was again mailed to the same individuals. A Phi Correlation Coefficient was computed between the two sets of answers. Questions were considered reliable at .70 and above, and only questions meeting that criteria were included in the revised opinionnaire.

A pretest served to identify instrument weaknesses in respondent comprehension, interview procedure, and testing time. Each pretest participant was given a copy of the opinionnaire and a set of instructions. Each participant completed the instrument and then was instructed to go back over the instrument and look for weaknesses in the opinionnaire. Participants were asked to list suggestions for improvement of the survey instrument. These suggestions, as well as areas of clarification, were discussed in an interview with the researcher at the conclusion of the pretest. The resulting pretests were analyzed and organized in order to determine if any differences existed on the method of scoring, coding, and interpreting the data from the instrument. All necessary correlations were incorporated into the

final opinionnaire, and the instrument was considered ready for research application. The same opinionnaire was administered to all legislators, State Board of Education members, and local school board chairpersons in Tennessee.

V. STATISTICAL PROCEDURE

The data were tabulated from the individual opinionnaires after the cut-off date of January 11, 1981. Initially the data were presented in basic summary form revealing percentages and most common answers for the entire sample. This was done to present an overall report of the three political populations in general. However, in order to address the research questions as stated in the problem of the study in Chapter I, the original sample was broken down in each of the following ways:

1. by type of political position
2. by years of training or education received
3. by age
4. by political affiliation
5. by length of political experience
6. by residence
7. by sex
8. by health content areas
9. by health services
10. by health practices
11. by fiscal aspects of health services

12. by fiscal aspects of health practices

The data were then computed and reported in a manner that would represent each of the various divisions. Kendall's coefficient of concordance, W , was used to determine if agreement existed among and between each of these divisions.

For the sake of comparison, sub-groups had to be established and identified within each category of the original sample. To compare responses of the three political groups (legislators, State Board of Education members, and local secondary school board chairpersons) according to the years of education they had received, the following groups were identified:

1. 12 years of high school or less
2. 1-4 years of college
3. 5 or more years of college

To compare responses of the political populations according to their age, the following sub-groups were identified:

1. less than 39 years of age
2. 39-48 years
3. 49-58 years
4. 59 years and older

To compare responses of the political populations according to their political affiliation, the following sub-groups were identified:

1. Democrat
2. Republican
3. independent
4. other

To compare responses of the political population according to their political experience, the following sub-groups were identified:

1. 4 years or less
2. 5-8 years
3. 9-12 years
4. 13-20 years
5. 20+ years

To compare responses of the political population according to their residence, the following sub-groups were identified:

1. rural
2. suburban
3. urban

As previously mentioned, the Kendall's coefficient of concordance, $\underline{W}$, was used to determine the degree of agreement among the various groupings of the three political samples. A major advantage of using $\underline{W}$ was that it yielded a coefficient of association for three or more variables, measured according to an ordinal scale, thus demonstrating the amount of agreement among groups according to several dimensions (Champion, 1981). The Spearman rank correlation

coefficient, r_s , was used when a coefficient of association was needed for two variable comparisons (e.g., income and educational level).

The chi-square test was used to determine if any significant differences existed within and between groups when variables were analyzed and measured according to a nominal scale. This test was used for situations where two independent samples and k-independent samples were being compared. The .05 level of significance was used for all comparisons.

VI. ASSUMPTIONS AND BIASES OF THE SURVEY

Tennessee legislators, State Board of Education members, and school board chairpersons are the primary policymakers who determine what shall and shall not be taught in the public schools, how much time will be allocated toward instruction, who will instruct school health, how health will be taught, types of health services which will be instituted, the health environment, and how much money will be spent in these areas. These policymakers also set other related educational priorities. Thus, the input from the policymaking population should aid in the formation of a school health proposal that will, hopefully, result in a more equitable and quality school health program for all Tennessee school children.

VII. SUMMARY

This chapter described the population, the opinionnaire design, pretesting the instrument, validation of the instrument, and the statistical procedures used in the study. Data were tabulated and grouped to answer research questions of the study using the SAS-79 computer package, statistical treatment of the data included use of the Kendall's coefficient of concordance, the Spearman rank correlation coefficient, and the chi-square statistic. The .05 level of significance was used in all statistical comparisons. Data presentation and analysis were made in Chapter IV.

CHAPTER IV

ANALYSIS OF THE DATA

I. INTRODUCTION

In this chapter data are analyzed from the administration of the opinionnaire to 272 politicians in Tennessee. The instrument was mailed to all 130 State legislators, all 16 State Board of Education members, and all 126 secondary school board chairpersons in Tennessee. Throughout this chapter, the term "political category" will be used to refer to persons representing different educational interests in the State of Tennessee. This should not be confused with "political affiliations" or "party" that refer to the common categories of Republican, Democrat, or American Independent.

The mailing of 272 opinionnaires and follow-up post-card reminders yielded 106 (39.6 percent) responses. One opinionnaire was excluded because a large portion of the instrument was not completed. Data from the opinionnaires were recorded on computer cards and analyzed, using the Statistical Analysis System (SAS-79) computer program package.

The chapter is organized into four major sections: 1) the introduction, 2) the sample description, 3) the statistical treatment of the data, and 4) the presentation of the data divided according to four major health education

areas (i.e. health education content, services, practices, and a comprehensive evaluation statement).

II. SAMPLE DESCRIPTION

Table 1 shows the distribution of the political population utilized in this study and the distribution of responses to the mailed opinionnaire. The first mailing of the opinionnaire was December 11, 1980, to 272 persons (consisting of 130 legislators, 16 members of the State Board of Education, and 126 local secondary school board chairpersons in Tennessee). Seventy persons, or 26.1 percent, responded to the initial mailing. A follow-up postcard reminder yielded an additional 36 responses for an overall response rate of 106 persons, or 39.6 percent, of the original population.

This response rate is considered normal compared with similar studies utilizing mailed questionnaires. (Four legislators were not included for various reasons; one was deceased, one was incarcerated, one seat (Knox County) was undesignated, and one person had moved leaving no forwarding address.)

The age distribution of the respondents by political category is presented in Table 2. The respondents ranged in age from 29 to 78, with the average age being 48 years. The largest age group consisted of politicians between the ages of 29 and 39, accounting for 32.5 percent of the total N.

TABLE 1. Proportionate Distribution of Responses to Opinionnaire by Three Political Populations, 1980-81

Political Population	Number of		Responses Follow-Up 1/11/81	Total	Percent	Overall Percent
	Initial Mailing 12/11/80					
126 Legislators*	23	14	37	29.4	34.9	
16 State Board of Education Members	7	2	9	56.3	8.5	
126 Local Secondary School Board Chairpersons	40	20	60	47.6	56.6	
266 Total	70	36	106		100.0	

*Total N excludes one legislator deceased, one incarcerated, one seat in Knox County undesignated, and one opinionnaire was not delivered.

TABLE 2. Age Distribution of Respondents According to Political Categories, 1980-81

Age	Political Categories				All Respondents	Percent
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board Chairpersons N ₃			
29-38	12	0	7		19	32.5
39-48	9	2	27		38	24.3
49-58	11	4	18		33	29.7
59 Years and Older	<u>5</u>	<u>3</u>	<u>8</u>		<u>16</u>	<u>13.5</u>
Total	37	8	60		106	100.0
Age Range =	29-68	39-72	34-78		29-78	
$\bar{X}$ =	46.1	53.9	45.5		48.0	

The second largest age group, 49-58, made up 29.7 percent of the N. The remaining responses came from politicians 59 years of age and older.

The distribution of respondents by sex and political category is presented in Table 3. The sample consisted of 91.5 percent males and 8.5 percent females. It is of interest to note that there were no female respondents in the State Board of Education category, although there were three women serving on the board at the time the study was conducted.

In Table 4 the political party affiliations of the respondents according to their particular political category are presented. Overall, 46.2 percent were Democrats, 39.6 percent were Republicans, 12.3 percent responded as Independents, and 1.9 percent indicated "other."

Presented in Table 5 are the distribution of the sample according to political category and degree of education. The majority (68.9 percent) of the respondents had graduated from a four-year college or university. Overall, most of the sample (98.2 percent) had completed high school or some form of higher education. However, no participants reported ever attending a vocational or technical school.

The distribution of the respondents by political category and years of political experience are shown in Table 6. These respondents ranged from "no experience" (newly elected persons) to 49 years of experience, the

TABLE 3. Distribution of the Sample According to Sex and Political Category, 1980-81

Sex	Political Categories				Percent
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board Chairpersons N ₃	All Respondents	
Male	34	9	54	97	91.5
Female	<u>3</u>	<u>0</u>	<u>6</u>	<u>9</u>	<u>8.5</u>
Total N	37	9	60	106	100.0

TABLE 4. Distribution of Sample by Political Category and Political Party, 1980-81

Political Party	Political Categories				All Respondents	Percent
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board Chairpersons N ₃			
Democrat	21	3	25		49	46.2
Independent	2	1	10		13	12.3
Republican	14	5	23		42	39.6
Other	<u>0</u>	<u>0</u>	<u>2</u>		<u>2</u>	<u>1.9</u>
Total N	37	9	60		106	100.0

TABLE 5. Distribution of Sample According to Education and Political Category, 1980-81

Education	Political Categories				All Respondents	Percent
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board			
			Chairpersons N ₃			
12th Grade of High School or Less	10	2	21	35	31.5	
4 Years of College	7	1	15	21	21.7	
5 Years or More of College	20	6	24	50	47.2	
Vocational or Technical School	0	0	0	0	0	
Total N	37	9	60	106	100.0	

Range = 9th grade to 8 years of college or university training

$\bar{X}$ = 4 years of college

TABLE 6. Distribution of Sample According to Political Category and Years of Political Experience, 1980-81

Years of Experience	Political Categories			All Respondents	Percent
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board Chairpersons N ₃		
4 Years or Less	16	4	13	33	31.1
5-8 Years	9	3	31	43	40.6
9-12 Years	9	1	5	15	14.2
13-20 Years	2	0	7	9	8.4
21 Years or More	<u>1</u>	<u>1</u>	<u>4</u>	<u>6</u>	<u>5.7</u>
Total N	37	9	60	106	100.0

Range = 0-49 years

X = 6 years

average being six years. While there were no substantial differences from one group of respondents to the next regarding overall years of experience, the group of legislators and local secondary school board chairpersons appeared to have proportionally more people with nine or more years of experience compared with the State Board of Education group. This was probably attributable to the fact that members of the State Board of Education were appointed by the governor, and the governor's term of office is comparatively shorter contrasted with the length of service associated with the persons in the other two categories.

In Table 7 the distribution of the sample according to political category and residence are presented. Overall, a majority of the sample (54.7 percent) consists of persons with urban-suburban residential backgrounds compared with the rural respondents. The groups of legislators and State Board of Education members were predominantly urban-suburban in their residential background (over 60 percent of each group designated themselves as such). In contrast the local secondary school board chairperson sample was evenly divided between rural and urban-suburban backgrounds.

III. STATISTICAL TREATMENT OF THE DATA

A primary objective of this study was to determine if the variables of age, sex, years of education, years of political experience, political position, political party,

TABLE 7. Distribution of Sample According to Political Category and Residence,
1980-81

Residence	Political Categories				All Respondents	Percent
	Legislators N ₁ %	State Board of Education N ₂ %	Local Secondary School Board Chairpersons N ₃ %			
Rural	15	40.0	3	33.3	30	50.0
Urban	7	18.9	5	55.6	9	15.0
Suburban	15	40.5	1	11.1	21	35.0
Total N	37	100.0	9	100.0	60	100.0
					48	45.3
					21	19.8
					37	34.9
					106	100.0

and residence had any effect upon the ranks assigned by the political samples to health related statements in the opinionnaire (see Appendix B). Specifically, the question to be answered was, "Does agreement exist among the political groups in the ranks assigned to secondary school health education content areas, services, and practices?" Kendall's coefficient of concordance was selected to determine the degree of agreement. A chi-square test was used to determine the significance of the resulting coefficient. The .05 level of significance was used for all comparisons.

The formula used to determine Kendall's coefficient of concordance, $\underline{W}$, has been described by Siegel (1956) as follows:

$$W = \frac{S}{\frac{1}{12} K^2 (N^3 - N)}$$

where:

S = sum of squares of the observed deviations from the mean of the summation of ranks;

K = numbers of sets of rankings;

N = number of cases ranked.

The chi-square formula used to determine the significance of the association, $\underline{W}$, is:

$$\chi^2 = K(N-1)\underline{W}$$

where:

K = number of sets of ranks;

N = number of cases ranked;

W = the observed coefficient of concordance.

The chi-square table was used to assess the significance of the observed χ^2 with N-1 degrees of freedom.

The Spearman rank-order correlation coefficient was used to compare perceptions of persons in different categories regarding health content, practices, and services. The formula used to compute the Spearman rank correlation coefficient has been described by Siegel (1956) as follows:

$$r_s = 1 - \frac{6\sum d^2}{N^3 - N}$$

where:

d^2 = the difference between the two sets of ranks squared;

N = the number of cases ranked.

A t test was used to determine the significance of the observed r_s . The formula for rho is:

$$t = r_s \sqrt{\frac{N-2}{1-r_s^2}}$$

where:

N = the number of cases ranked;

r_s = the observed rho value.

The observed t value was then evaluated by using N-2 degrees of freedom (two-tailed test).

The chi-square test was used to determine if significant differences existed between the different groups according to various salient characteristics.

IV. DATA PRESENTATION

In this section, four major health education areas are examined in detail. Respondents were presented a listing of health related statements pertaining to health content, health service, instructional practices, and a comprehensive health evaluation statement. The following represents cross tabulation of these health areas with salient variables such as age, sex, and years of political experience. In order to avoid redundancy in the findings, the terms "significant" and "significance" refer to the .05 level of significance selected at the outset as one of the crucial decisions rules associated in the all statistical tests of significance applied.

Secondary School Health Education Content Areas

The first set of statements presented to respondents concerned health content. These statements included such topics as dieting, sex education, mental health, and death education.

Secondary school health education content areas are ranked in order to importance by the three political samples

in Table 8. These rankings were determined by averaging the weight assigned by each sample to the specific items on the opinionnaire. There was a high degree of agreement among the three groups on the rankings of the 18 content areas ($W = .81, P < .05$).

Those areas receiving the highest priority, according to the groups rankings, were first aid, food and nutrition, and physical and dental health. There was unanimous agreement on death education having the lowest priority.

Other areas of low priority emerged as follows: sex education, health/life insurance, marriage and parenting, dieting and consumerism. It may very well be that these health content areas received the least consideration because of the fact that they are a part of one's everyday experiences in family life, religion, and early childhood education.

The rankings of male and female respondents for the health education content areas are presented in Table 9. There is a significant association between the two sets of ranks assigned ($r_s = .85, P < .05$). According to the rankings, two most important health content areas were first aid and food and nutrition. The least important areas as perceived by both sexes were death education, sex education, and health/life insurance. It would appear that nonsignificant differences exist between males and females in the sample concerning health content area priorities. It should

TABLE 8. Statistical Summary of Political Groups' Perceptions of Health Content Areas

Health Content Areas	Ranks by Sample			Sum of Ranks
	Legislators N ₁	State Board of Education N ₂	Local Secondary School Board Chairpersons N ₃	
8. Structure/Function of Body	4	3.5	7.5	15
9. Food/Nutrition	3	3.5	4	10.5
10. Physical Activity/Play	1.5	12	7.5	21
11. Rest/Sleep/Relaxation	7.5	10	11	28.5
12. Mental Health	12	8	10	30
13. Consumerism	15	14	12	41
14. Safety/Disaster/Civil Defense	9	6	13	28
15. First Aid	5	1.5	1	7.5
16. Alcohol/Drug Abuse	10	12	2.5	24.5
17. Smoking/Use of Tobacco	11	9	2.5	22.5
18. Disease Prevention	7.5	6	5.5	19
19. Health/Life Insurance	16	15.5	16.5	48
20. Death Education	18	18	18	54
21. Driver Education	1.5	6	9	16.5
22. Physical/Dental Health	6	1.5	5.5	13
23. Dieting	14	12	15	41
24. Sex Education	17	15.5	16.5	49
25. Marriage/Parenting	13	17	14	44
				<u>513</u>

W = .81 $\chi^2 = 41.36$ (P < .05 < .001) df = 2

TABLE 9. Statistical Summary of Males' and Females' Perceptions of Health Content Areas

Health Content Areas	Rank by Sex		Sum of Rank Total N = 106	D	D ²
	Male N ₁ = 97	Female N ₂ = 9			
8. Structure/Function of Body	5.5	2	7.5	3.5	12.25
9. Food/Nutrition	2	2	4	0	0
10. Physical Activity/Play	3	5	8	2	4
11. Rest/Sleep/Relaxation	10	9	19	1	1
12. Mental Health	11	9	20	2	4
13. Consumerism	13	13.5	26.5	.5	.25
14. Safety/Disaster/Civil Defense	12	5	17	7	49
15. First Aid	1	2	3	1	1
16. Alcohol/Drug Abuse	8	9	17	1	1
17. Smoking/Use of Tobacco	9	9	18	0	0
18. Disease Prevention	7	13.5	20.5	6.5	42.25
19. Health/Life Insurance	16	15	31	1	1
20. Death Education	18	17	35	1	1
21. Driver Education	4	5	9	1	1
22. Physical/Dental Health	5.5	9	14.5	3.5	12.25
23. Dieting	15	12	27	3	9
24. Sex Education	17	18	35	1	1
25. Marriage/Parenting	14	16	30	2	4
			352		

$r_s = .85$ $t_{obs} = 6.010$ ($P < .05$) $df = 16$ $D = \text{difference}$

be noted that the small number of females lends an amount of distortion to these findings. While it is virtually impossible to assess accurately the distorting effect of the small female N, the consistency of rankings between the sexes is nonetheless significant.

In Table 10 the distribution of rankings of the items originally shown in Table 8 according to residential background are presented. There was a significant association between these groups on item rankings ($W = .90$, $P < .05$). Food/nutrition, driver education, and first aid were generally rated as most important across all groups, while death education, health/life insurance, and sex education received the least consideration. It is difficult to uncover serious discrepancies between these groups, regarding their rankings of health content areas because of such a high degree of association. The urban aggregate ranked driver education as important compared with their rural and suburban counterparts. Another finding was that rural respondents tended to emphasize the importance of physical activity and play to a greater degree than either suburban or urban respondents. Finally, rural and suburban respondents emphasized first aid to a greater degree than urban respondents.

A summary of rankings of health content areas according to the respondents' political party affiliation is presented in Table 11. Again, the association between the four sets of ranks was moderately high ($W = .61$, $P < .05$). The

TABLE 10. Statistical Summary of Residence Groups' Perceptions of Health Content Areas

Health Content Areas	Rank by Residence Groups			Sum of Rank
	Rural N ₁ = 48	Suburban N ₂ = 37	Urban N ₃ = 21	
8. Structure/Function of Body	3.5	3.5	6.5	13.5
9. Food/Nutrition	1.5	2	2.5	6
10. Physical Activity/Play	3.5	6	6.5	16
11. Rest/Sleep/Relaxation	11	11	10.5	32.5
12. Mental Health	12	10	12.5	34.5
13. Consumerism	13	14.5	10.5	38
14. Safety/Disaster/Civil Defense	10	12	17	39
15. First Aid	1.5	1	9	11.5
16. Alcohol/Drug Abuse	7.5	9	4.5	21
17. Smoking/Use of Tobacco	9	8	8	25
18. Disease Prevention	5.5	7	4.5	17
19. Health/Life Insurance	16	17	16	49
20. Death Education	18	18	18	54
21. Driver Education	5.5	3.5	1	10
22. Physical/Dental Health	7.5	5	2.5	15
23. Dieting	15	13	12.5	40.5
24. Sex Education	17	16	15	48
25. Marriage/Parenting	14	14.5	14	42.5
				<u>513</u>

W = .90 $\chi^2 = 46.14$ (P < .05 < .001) df = 2

TABLE 11. Statistical Summary for Health Content Areas by Political Parties

Health Content Areas	Rank by Sample				Sum of Rank Total N = 106
	Democrat N ₁ = 49	Republican N ₂ = 42	Independent N ₃ = 13	Other N ₄ = 2	
8. Structure/Function of Body	5	3.5	5.5	11	25
9. Food/Nutrition	1	3.5	5.5	5.5	15.5
10. Physical Activity/Play	2.5	2	10.5	11	26
11. Rest/Sleep/Relaxation	9.5	10	12	11	42.5
12. Mental Health	11	12	5.5	11	39.5
13. Consumerism	14	13	10.5	16.5	54
14. Safety/Disaster/Civil Defense	12	11	13	1	37
15. First Aid	4	1	5.5	2.5	13
16. Alcohol/Drug Abuse	8	8.5	2.5	11	30
17. Smoking/Use of Tobacco	9.5	5	1	11	26.5
18. Disease Prevention	7	6.5	2.5	16.5	32.5
19. Health/Life Insurance	16	16.5	15.5	16.5	64.5
20. Death Education	18	18	17.5	16.5	70
21. Driver Education	2.5	6.5	9	5.5	23.5
22. Physical/Dental Health	6	8.5	8	2.5	25
23. Dieting	15	14	14	11	54
24. Sex Education	17	16.5	17.5	5.5	56.3
25. Marriage/Parenting	13	15	15.5	5.5	49
					<u>684</u>

W = .61

 $\chi^2 = 41.88$ (P < .05 < .001)

df = 16

extremely small N for 2 in category #4, "other," was included in the computation of W. Had it been excluded, the resulting W would have been considerably higher. For instance, the degree of agreement among Republicans, Democrats, and Independents was ($W = .69$, $P < .05$). It is evident that the health needs of the state cut across political party lines and that no single issue (according to the rankings assigned the health content areas) received substantially greater priority than another according to one's political affiliation. Overall, first aid and food/nutrition areas received the most frequent attention from respondents. The least frequently selected categories included death education, health/life insurance, and sex education.

The responses of the political samples to health content areas by years of political experience is presented in Table 12. Data in Table 12 reveal a strong association between the various age groups concerning priorities given to health content areas ($W = .74$, $P < .05$). Those content areas cited by the respondents as being most important to include in a secondary education curriculum were first aid and food/nutrition. Those areas receiving the least priority were death education, sex education, and health/life insurance. Death education was ranked lowest by all years of experience groups with the exception of those having 21 or more years of experience.

TABLE 12. Statistical Summary of Political Experience Groups' Perceptions of Health Content Areas

Health Content Areas	Rank by Experience Groups					Sum of Rank Total N = 106
	4 Years or Less N ₁ = 33	5-8 Years N ₂ = 43	9-12 Years N ₃ = 15	13-20 Years N ₄ = 9	21+ Years N ₅ = 6	
8. Structure/Function of Body	6.5	2.5	2.5	11.5	7.5	30.5
9. Food/Nutrition	2.5	1	8	2.5	3.5	17.5
10. Physical Activity/Play	4	5	5	6	9.5	29.5
11. Rest/Sleep/Relaxation	9.5	11.5	12	9	9.5	51.5
12. Mental Health	11	10	10.5	16	3.5	51
13. Consumerism	17	11.5	13	9	11.5	62
14. Safety/Disaster/Civil Defense	12	13	10.5	11.5	11.5	58.5
15. First Aid	1	2.5	2.5	2.5	7.5	16
16. Alcohol/Drug Abuse	2.5	7.5	14	2.5	3.5	30
17. Smoking/Use of Tobacco	8	9	5	6	3.5	31.5
18. Disease Prevention	9.5	5	8	6	3.5	32
19. Health/Life Insurance	16	17	15	14.5	13	75.5
20. Death Education	18	18	18	18	16	88
21. Driver Education	5	7.5	1	2.5	14	30
22. Physical/Dental Health	6.5	5	5	9	3.5	29
23. Dieting	14	15	8	14.5	16	67.5
24. Sex Education	15	16	17	17	18	83
25. Marriage/Parenting	13	14	16	13	16	72
						855

W = .74 $\chi^2 = 63.16$ (P < .05 < .001) df = 16

Because of the high degree of agreement between these experience groupings, it is difficult to delineate clear differences between them regarding specific health content areas. The only health content areas where substantial discrepancies occur are structure/function of body, food/nutrition, alcohol/drug abuse, and driver education. In these instances, some experience groups judged particular topic areas to be far more important than others. But as has been noted above, the large observed W suggests little variation from one grouping to the next regarding their overall rankings of these health content areas.

The ranking of health content areas by persons with different degrees of education is presented in Table 13. The degree of agreement was determined to be significant statistically ($W = .86$, $P < .05$). Again, little can be said that can distinguish one group from another in terms of their overall rankings of these health content areas. Those areas receiving the most important consideration generally were first aid, food/nutrition, physical/dental health, and structure/function of body. Those areas receiving least consideration by these groups included death education, sex education, dieting, and marriage/parenting.

One interesting observation is that those persons with the least amount of education (i.e., 12 years of school or less) differed less from the most educated group (i.e., five or more years of college) than either of these groups

TABLE 13. Statistical Summary of Perceptions of Health Content Areas According to Years of Education

Health Content Areas	Rank by Educational Level			Sum of Rank Total N = 106
	12 Years of School or Less N ₁ = 35	1-4 Years of College N ₂ = 21	5 or More Years of College N ₃ = 50	
8. Structure/Function of Body	5	7.5	3	15.5
9. Food/Nutrition	2	7.5	1	10.5
10. Physical Activity/Play	4	7.5	4.5	16
11. Rest/Sleep/Relaxation	10.5	11.5	10	32
12. Mental Health	12	7.5	12	31.5
13. Consumerism	14	11.5	14	39.5
14. Safety/Disaster/Civil Defense	10.5	14	11	35.5
15. First Aid	1	5	2	8
16. Alcohol/Drug Abuse	7.5	10	4.5	22
17. Smoking/Use of Tobacco	7.5	2	9	18.5
18. Disease Prevention	7.5	3	6	16.5
19. Health/Life Insurance	17	15	16	48
20. Death Education	18	17	18	53
21. Driver Education	7.5	1	7	15.5
22. Physical/Dental Health	3	4	8	15
23. Dieting	15	13	15	43
24. Sex Education	16	18	17	51
25. Marriage/Parenting	13	16	13	42
				<u>513</u>

W = .86 $\chi^2 = 44.18$ (P < .05 < .001) df = 16

differed from the moderately educated group (i.e., 1-4 years of college). In other words, there were greater differences in rankings observed to occur between the least educated group and the moderately educated group compared with the most educated group. Also, there were more substantial differences in rankings occurring between the most educated group and the moderately educated group compared with the least educated group. Again, it must be noted that since the overall observed W was quite high and, therefore, indicated a strong degree of agreement between all groupings according to educational attainment, no remarkable differences were observed overall considering all health content areas.

In Table 14 the rankings of health content areas according to various age groupings are presented. There was a strong association which was significant statistically ($W = .78$, $P < .05$). Those areas receiving the greatest amount of attention by persons across all age groupings include food/nutrition and first aid. Those areas receiving the least amount of consideration for inclusion in a secondary school curriculum are death education, sex education, and health/life insurance. Although the differences were not significant between the different age groups, those older persons (59 years of age and older) placed less emphasis on the alcohol/drug abuse and smoking/use of tobacco areas compared with those younger persons. No

TABLE 14. Statistical Summary of Perceptions of Health Content Areas by Age

Health Content Areas	Ranking by Age				Sum of Rank Total N = 106
	Less than 39 Years N ₁ = 19	39-48 Years N ₂ = 38	49-58 Years N ₃ = 33	59 Years and Older N ₄ = 16	
8. Structure/Function of Body	2.5	9	5	2.5	19
9. Food/Nutrition	1	7.5	1	1	10.5
10. Physical Activity/Play	4	7.5	2	7	20.5
11. Rest/Sleep/Relaxation	5.5	11.5	11	7	20.5
12. Mental Health	8	10	13.5	10	41.5
13. Consumerism	12	14.5	13.5	11.5	51.5
14. Safety/Disaster/Civil Defense	14	13	11	7	45
15. First Aid	5.5	1	4	4	14.5
16. Alcohol/Drug Abuse	2.5	6	6.5	13	28
17. Smoking/Use of Tobacco	8	5	6.5	11.5	31
18. Disease Prevention	8	4	8.5	7	27.5
19. Health/Life Insurance	13	16	17	15	61
20. Death Education	16.5	18	18	18	70.5
21. Driver Education	10.5	3	3	7	23.5
22. Physical/Dental Health	10.5	2	8.5	2.5	23.5
23. Dieting	15	11.5	15	17	58.5
24. Sex Education	18	17	16	16	67
25. Marriage/Parenting	16.5	14.5	11	14	56
					<u>684</u>

W = .78 $\chi^2 = 53.32$ (P < .05 < .001) df= 16

information was available to enable us to determine which of the respondents were smokers or nonsmokers/drinkers/non-drinkers.

Summarizing the first set of tables, briefly, it may be said that regardless of political affiliation, age, sex, years of education, years of experience, socio-cultural background, or political position (e.g., legislator, school board member, etc.), the health content areas receiving the most important consideration for inclusion in a secondary education program were first aid, food/nutrition, and physical and dental health. Those areas receiving the least consideration included death education, sex education, marriage and parenting, and health and life insurance. Virtually all observed W's were significant statistically, and therefore, few, if any inferences could be drawn concerning substantial points of differences between the various groups classified according to such variables as age and sex, for example. It will be remembered that the urban-rural difference observed was to the effect that first aid was emphasized by rural residents, while driver education was emphasized by those of urban residence. This distinction may be helpful when planners begin to implement changes and additions to secondary health education curriculums in the future.

School Health Services

Eight school health services were identified in the study. The three political groups' perceptions of these health services are presented in Table 15. Again, items were ranked according to the means of weights assigned each. There was considerable agreement among the three political groups (legislators, members of the State Board of Education, and local school board chairpersons) regarding the rankings of these health services ($W = .80, P < .05$). The health services of most importance to these persons were provisions for school nurses and the inclusion of health committees. The least important services were free school lunches and the provision of a physician in the school.

A statistical summary of the perceptions of health services according to sex is presented in Table 16. A high degree of agreement was observed between sexes regarding the importance of the various health services potentially available to secondary schools ($r_s = .89, P < .05$). Again, the primary services believed to be most important to both sexes were school nurses and health committees. The least importance was assigned to the provision of free school lunches and the employment of physicians for the schools. No significant differences exist between males and females regarding these various health services.

A statistical summary of perceptions of health services according to one's residence is presented in Table 17. The

TABLE 15. Statistical Summary of Perceptions of Health Services According to Political Group

Health Services	Rank by Political Group			Sum of Rank Total N = 106
	Legislators N ₁ = 37	State Board of Education N ₂ = 9	Local Secondary School Board Chairpersons N ₃ = 60	
27. Free Physical and Dental Exam	7	5	7	19
28. Health Committee	2	2.5	2	6.5
29. School Nurses	1	1	1	3
30. Physicians and Dentists Consultation	3	4	4	11
31. School Lunches Free to All	8	8	6	22
32. Seat Belts in Buses	4	6.5	3	13.5
33. Raise Driver's License Age to 18	6	2.5	5	13.5
34. School Employ M.D.	5	6.5	8	19.5
				<u>108</u>

$$W = .80 \quad \chi^2 = 16.89 \quad (P < .05 < .02) \quad df = 7$$

TABLE 16. Statistical Summary of Perception of Health Services According to Sex

Health Services	Rank by Sex		Rank	D	D ²
	Male N ₁ = 97	Female N ₂ = 9			
27. Free Physical and Dental Exam	7	5.5	12.5	1.5	2.25
28. Health Committee	2	1	3	1	1
29. School Nurses	1	3	3	1	1
30. Physicians and Dentists Consultation	3	4	7	1	1
31. School Lunches Free to All	8	7.5	15.5	.5	.25
32. Seat Belts in Buses	4	3	7	1	1
33. Raise Driver's License Age to 18	5	5.5	10.5	.5	.25
34. School Employ M.D.	6	7.5	13.5	1.5	2.25
			<u>72</u>		

$$r_s = .89$$

$$t = 6.53 \text{ (P} < .05\text{)}$$

$$df = 6$$

TABLE 17. Statistical Summary of Perceptions of Health Services According to One's Residence

Health Services	Rank by Residence			Sum of Rank Total N = 106
	Rural N ₁ = 48	Suburban N ₂ = 21	Urban N ₃ = 37	
27. Free Physical and Dental Exam	7	7	6	20
28. Health Committee	2	2	2	6
29. School Nurses	1	1	1	3
30. Physicians and Dentists Consultation	3	4.5	3	10.5
31. School Lunches Free to All	6	8	7	21
32. Seat Belts in Buses	4	3	4.5	11.5
33. Raise Driver's License Age to 18	5	4.5	8	17.5
34. School Employ M.D.	8	6	4.5	18.5
				<u>108</u>

$$W = .84 \quad \chi^2 = 17.72 \text{ (P < .05)} \quad df = 7$$

three residence groups (i.e., rural, suburban, and urban) strongly agreed as to what were perceived as the most important service. Again, the provision of school nurses and health committees received the most attention, while the least popular service continued to be the provision of free school lunches.

In Table 18 a summary of the importance of health services by political party is presented. The priority assigned various health services continues to be in the areas of school nurses and health committees, while the services deemed least important to include were free school lunches and provisions for free physical and dental examinations. The degree of agreement observed between the four groups was significant statistically ($W = .83$, $P < .05$).

Tables 19, 20, and 21 summarize the rankings assigned the various health services by the different groupings of respondents according to years of political experience, level of educational attainment, and age. In each table, significant associations were observed for all groups. Regardless of the years of experience possessed by the various respondents, their age differences, or their years of educational attainment, the services emerging as most important continued to be the provision of school nurses and health committees. In each of the tables, it can be seen that the services receiving the least priority continued to be the provision of free school lunches, the provision of

TABLE 18. Statistical Summary of the Importance of Health Services by Political Party

Health Services	Rank by Political Party				Sum of Rank Total N = 106
	Democrat N ₁ = 49	Republican N ₂ = 42	Independent N ₃ = 13	Other N ₄ = 3	
27. Free Physical and Dental Exam	7	7	5.5	5	24.5
28. Health Committee	2	1	2	2	7
29. School Nurses	1	2	1	2	6
30. Physicians and Dentists Consultation	3	5	4	5	17
31. School Lunches Free to All	8	8	7.5	8	31.5
32. Seat Belts in Buses	4	4	3	2	13
33. Raise Driver's License	5	3	5.5	7	24.5
34. School Employ M.D.	6	6	7.5	5	24.5
					<u>144</u>

$$W = .83 \quad \chi^2 = 23.50 \quad (P < .05 < .01)$$

TABLE 19. Statistical Summary of Perceptions of Health Services According to Years of Experience

Health Services	Rank by Years of Experience					Sum of Rank Total N = 106
	4 Years or Less N ₁ = 33	5-8 Years N ₂ = 43	9-12 Years N ₃ = 15	13-20 Years N ₄ = 9	21+ Years N ₅ = 6	
27. Free Physical and Dental Exam	7	8	2	8	7.5	32.5
28. Health Committee	1	2	5	3.5	1.5	13
29. School Nurses	2	1	1	1	1.5	6.5
30. Physicians and Dentists Consultation	4	4	4	6	3.5	21.5
31. School Lunches Free to All	8	6	8	5	6	33
32. Seat Belts in Buses	3	5	3	3.5	5	19.5
33. Raise Driver's License Age to 18	5	3	7	2	3.5	20.5
34. School Employ M.D.	6	7	6	7	7.5	33.5
						<u>180</u>

$$W = .65 \quad \chi^2 = 23.05 \quad (P < .05 < .01) \quad df = 7$$

TABLE 20. Statistical Summary of Perceptions of Health Services According to the Level of Educational Attainment

Health Services	Rank by Education			Sum of Rank Total N = 106
	12 Years of School of Less N ₁ = 35	1-4 Years of College N ₂ = 21	5 or More Years of College N ₃ = 30	
27. Free Physical and Dental Exam	7	7	7	21
28. Health Committee	2	2	2	6
29. School Nurses	1	1	1	3
30. Physicians and Dentists Consultation	3	5	3	11
31. School Lunches Free to All	6	8	8	22
32. Seat Belts in Buses	4	3	5	11
33. Raise Driver's License Age to 18	5	4	5	14
34. School Employ M.D.	8	6	6	20
				<u>108</u>

$$W = .92 \quad \chi^2 = 19.44 \quad (P < .05 < .01) \quad df = 7$$

TABLE 21. Statistical Summary of Perceptions of Health Services According to Age

Health Services	Rank by Age				Sum of Rank Total N = 106
	Less than 39 Years N ₁ = 19	39-48 Years N ₂ = 38	40-58 Years N ₃ = 33	59 Years and Older N ₄ = 16	
27. Free Physical and Dental Exam	7	7	6	8	28
28. Health Committee	2	2	2	6.5	12.5
29. School Nurses	3	1	1	1	6
30. Physicians and Dentists Consultation	4	3	3	3.5	13.5
31. School Lunches Free to All	8	8	8	2	26
32. Seat Belts in Buses	1	5	4	6.5	16.5
33. Raise Driver's License Age to 18	5	4	5	3.5	17.5
34. School Employ M.D.	6	6	7	5	24
					<u>144</u>

$$W = .59 \quad \chi^2 = 16.54 \text{ (} P < .05 \text{)} \quad df = 7$$

physicians, and free physical and dental examinations.

It would appear from all indications that generally the services most desired by these respondents were school nurses and the provision of health committees. An overall assessment of these participants' responses toward the least desirable services would be that free school lunches and the inclusion of physicians in the school would not be feasible objectives for secondary school health education planners.

School Health Practices

Thirteen school health practices were identified in the study. Table 22 presents a summary of the three political groups' perception of these health practices. There was considerable agreement among the three political groups (legislators, members of the State Board of Education, and local school board chairpersons) regarding ranking of health practices ($W = .84$, $P < .05$).

A close inspection of the data in Table 22 revealed that the various groups related as most important were teacher inservice training, a well planned program, and an emphasis on the application to lifestyle. This underscores the importance of a "hands on" approach to health education generally expressed by these different political groups. The health practices receiving the least priority were expanding the health course to two semesters instead of one for senior high school and the provision that the instructor be

TABLE 22. Summary of Political Groups' Perceptions of Health Practices

Health Practices	Rank by Political Groups			Sum of Rank Total N = 106
	Legislators N ₁ = 37	State Board of Education N ₂ = 9	Local Secondary School Board Chairpersons N ₃ = 60	
35. Well-Planned Program	3	1.5	1	5.5
36. Equal Emphasis	8	11	6.5	25.5
37. Textbooks Updated	5.5	7	5	17.5
38. Separate Course	10	8.5	8	26.5
39. Integrated Course	9	10	13	32
40. Written Plan	5.5	5.5	4	15
41. Psychological Exam for Teachers	7	3	10	20
42. Junior High Two Semesters	11	8.5	12	31.5
43. Evaluation to Appraise Effectiveness	4	1.5	6.5	16
44. Applicable to Lifestyle	2	4	2	8
45. Senior High Two Semesters	12	13	11	36
46. Instructor Certified with Major	13	12	9	34
47. Teacher Inservice Training	1	1.5	3	5.5
				<u>273</u>

$$W = .84 \quad \chi^2 = 30.57 \quad (P < .05 < .01) \quad df = 12$$

certified to teach with a major in health education.

In Tables 23 through 28 summaries of the rankings of health practices in secondary schools according to sex, one's residential background, political party, years of political experience, one's level of educational attainment, and one's age are presented. There is a consistent pattern observed throughout each of the tables. In all instances, priorities were given to inservice training for teachers, well-planned programs, and to applications of health courses to student's lifestyles. Significant associations were observed to occur regardless of the particular kind of grouping (e.g., sex, years of educational experience, or residential background).

At the other end of the continuum, those practices deemed least suitable by these groups (regardless of the control variable utilized) included the expansion of health to two semesters instead of one for senior high school, and requiring that persons who taught health education courses must be certified with a major in school health.

The political groups responding in the present research categorically supported the notion that inservice teacher training in the areas of first aid and emergency services be required as a part of a well-rounded set of health-related services. There also appeared to be unanimity concerning the importance of a comprehensive well-planned program of health instruction in secondary schools.

TABLE 23. Statistical Summary of Perceptions of Health Practices According to Sex

Health Practices	Rank by Sex		Sum of Rank Total N = 106	D	D ²
	Male N ₁ = 97	Female N ₂ = 9			
35. Well-Planned Program	2	1	3	1	1
36. Equal Emphasis	7.5	5.5	13	2	4
37. Textbooks Updated	5	8.5	13.5	3.5	12.25
38. Separate Course	9	8.5	17.5	.5	.25
39. Integrated Course	11	13	24	2	4
40. Written Plan	4	3.5	7.5	.5	.25
41. Psychological Exam for Teachers	7.5	8.5	16	1	1
42. Junior High Two Semesters	13	11.5	24.5	1.5	2.25
43. Evaluation to Appraise Effectiveness	6	5.5	11.5	.5	.25
44. Applicable to Lifestyle	3	3.5	6.5	.5	.25
45. Senior High Two Semesters	12	11.5	23.5	.5	.25
46. Instructor Certified with Major	10	8.5	18.5	1.5	2.25
47. Teacher Inservice Training	1	2	3	1	1
			182		

$$r_s = .92 \quad (t = 6.744, P < .05 < .01)$$

$$df = 11$$

TABLE 24. Summary of Perceptions of Health Practices According to One's Residence

Health Practices	Rank by Residence Groups			Sum of Rank Total N = 106
	Rural N ₁ = 48	Suburban N ₂ = 37	Urban N ₃ = 21	
35. Well-Planned Program	2	2	2.5	6.5
36. Equal Emphasis	7	8	4.5	19.5
37. Textbooks Updated	5	6	4.5	15.5
38. Separate Course	9	7	9.5	25.5
39. Integrated Course	11	11	13	35
40. Written Plan	4	4	7	15
41. Psychological Exam for Teachers	6	9	8	23
42. Junior High Two Semesters	13	12	9.5	34.5
43. Evaluation to Appraise Effectiveness	8	5	6	19
44. Applicable to Lifestyle	1	3	1	5
45. Senior High Two Semesters	12	13	11.5	36.5
46. Instructor Certified with Major	10	10	11.5	31.5
47. Teacher Inservice Training	3	1	2.5	6.5
				<u>273</u>

$$W = .91 \qquad \chi^2 = 32.81 \quad (P < .05 < .01) \qquad df = 12$$

TABLE 25. Summary of the Importance of Various Health Practices By Political Party

Health Practices	Rank by Political Parties				Sum of Rank Total N = 106
	Democrat N ₁ = 49	Republican N ₂ = 42	Independent N ₃ = 13	Other N ₄ = 2	
35. Well-Planned Program	1.5	2	1.5	5	10
36. Equal Emphasis	6.5	7.5	5	9	28
37. Textbooks Updated	5	6	8	1.5	20.5
38. Separate Course	9	10.5	8	5	32.5
39. Integrated Course	11	13	10	9	43
40. Written Plan	4	4	5	3	16
41. Psychological Exam for Teachers	8	7.5	5	12.5	33
42. Junior High Two Semesters	13	10.5	13	9	45.5
43. Evaluation to Appraise Effectiveness	6.5	6	8	9	28.5
44. Applicable to Lifestyle	3	3	3	1.5	10.5
45. Senior High Two Semesters	11	12	12	12.5	47.5
46. Instructor Certified with Major	11	9	11	5	36
47. Teacher Inservice Training	1.5	1	1.5	9	13
					<u>364</u>

$$W = .71 \quad \chi^2 = 34.23 \quad (P < .05 < .001) \quad df = 12$$

TABLE 26. Summary of Perceptions of Health Practices According to Years of Political Experience

Health Practices	Rank by Experience Groups					Sum of Rank Total N = 106
	4 Years or Less N ₁ = 33	5-8 Years N ₂ = 43	9-12 Years N ₃ = 15	13-20 Years N ₄ = 9	21+ Years N ₅ = 6	
35. Well Planned Program	3	1	1.5	2	2.5	10
36. Equal Emphasis	9	7	9.5	5	4.5	35
37. Textbooks Updated	6	5	5	3.5	9	28.5
38. Separate Course	8	8	9.5	9	10	44.5
39. Integrated Course	11.5	11.5	13	12.5	7	55.5
40. Written Plan	4	4	4	6	7	25
41. Psychological Exam for Teachers	7	10	6.5	8	4.5	36
42. Junior High Two Semesters	10	11.5	12	12.5	12.5	58.5
43. Evaluation to Appraise Effectiveness	5	6	8	7	7	33
44. Applicable to Lifestyle	2	2.5	3	1	2.5	11
45. Senior High Two Semesters	11.5	13	11	10.5	11	57
46. Instructor Certified with Major	13	9	6.5	10.5	12.5	51.5
47. Teacher Inservice Training	1	2.5	1.5	3.5	1	9.5
						455

$$W = .83 \quad \chi^2 = 50.34 \quad (P < .05 < .001) \quad df = 12$$

TABLE 27. Summary of Perceptions of Health Practices According to the Level of Education

Health Practices	Rank by Educational Level			Sum of Rank Total N = 106
	12 Years of School or Less N ₁ = 35	1-4 Years of College N ₂ = 21	5 or More Years of College N ₃ = 50	
35. Well-Planned Program	3	3	1	7
36. Equal Emphasis	8	5	8	21
37. Textbooks Updated	6	6.5	5	17.5
38. Separate Course	11	8.5	8	27.5
39. Integrated Course	9.5	13	13	35.5
40. Written Plan	4	4	4	12
41. Psychological Exam for Teachers	7	10	8	25
42. Junior High Two Semesters	13	12	10.5	35.5
43. Evaluation to Appraise Effectiveness	5	6.5	6	17.5
44. Applicable to Lifestyle	2	2	3	7
45. Senior High Two Semesters	12	11	12	35
46. Instructor Certified with Major	9.5	8.5	10.5	28.5
47. Teacher Inservice Training	1	1	2	4
				273

W = .92 $\chi^2 = 33.35$ (P < .05 < .001) df = 12

TABLE 28. Summary of Perceptions of Health Practices According to Age

Health Practices	Rank by Age				Sum of Rank Total N = 106
	Less than 39 Years N ₁ = 19	39-48 Years N ₂ = 38	49-58 Years N ₃ = 33	59 Years and Older N ₄ = 16	
35. Well-Planned Program	3	1	3	1.5	8.5
36. Equal Emphasis	8	10	5.5	12	35.5
37. Textbooks Updated	4.5	5	8	5	22.5
38. Separate Course	9.5	8	9	10.5	37
39. Integrated Course	6	13	11	8.5	38.5
40. Written Plan	4.5	4	4	4	16.5
41. Psychological Exam for Teachers	13	7	7	6.5	33.5
42. Junior High Two Semesters	11	12	12.5	8.5	44
43. Evaluation to Appraise Effectiveness	7	6	5.5	6.5	25
44. Applicable to Lifestyle	2	3	1	3	9
45. Senior High Two Semesters	9.5	11	12.5	13	46
46. Instructor Certified with Major	12	9	10	10.5	41.5
47. Teacher Inservice Training	1	2	2	1.5	6.5
					364

$$W = .82 \quad \chi^2 = 39.57 \quad (P < .05 < .001) \quad df = 12$$

V. GENERAL STATEMENT ABOUT HEALTH EDUCATION PROGRAM

One item included on the opinionnaire was a general statement to the effect that "a good health education program should help to reduce medical problems, medical costs, and help to prevent some diseases." Space was included for written comments, although in almost every instance, respondents failed to make such comments.

The perceptions of the three political groupings of respondents toward the general health education item are presented on Table 29. Also included in the table are agree-disagree responses of the participants according to age, sex, residential background, political party affiliation, political experience, and level of education. An examination of Table 29 shows that regardless of the variable used for control (e.g., sex, residential background, etc.), a clear majority of respondents in every instance agreed with the idea that good health education programs should be designed to deal with health-related problems. This is consistent with the practical notion that good health programs should be instrumental in alleviating health problems of various kinds.

One final observation is in order here. Regarding health services and instructional practices, these legislators and educators were asked to agree or disagree with various statements. In addition, yes-no responses were placed adjacent to agree-disagree designations. These yes-

TABLE 29. Perceptions of Legislators, State Board of Education Members, and Local School Board Chairpersons Toward Statement 26 ("A Good Health Education Program Should Help Reduce Medical Problems, Medical Costs, and Help to Prevent Some Diseases"); Other Variables are Presented, 1980-81

Variable	Responses			Total %
	Agree %	Disagree %	Undecided %	
POLITICAL GROUPING				
Legislators	81.1	0	18.9	100 (N = 37)
State Board of Education Members	100	0	0	100 (N = 9)
Local School Board Chairpersons	85.8	1.9	12.3	100 (N = 60)
AGE				
Less than 39 Years	84.2	0	15.8	100 (N = 19)
39-48 Years	86.8	5.3	7.9	100 (N = 38)
49-58 Years	87.9	0	12.1	100 (N = 33)
59 Years and Older	81.2	0	18.8	100 (N = 16)
SEX				
Male	84.5	2	13.3	100 (N = 97)
Female	100	0	0	100 (N = 9)
RESIDENTIAL BACKGROUND				
Rural	81.2	4.1	14.6	100 (N = 48)
Suburban	91.9	0	8.1	100 (N = 37)
Urban	82.3	0	17.7	100 (N = 21)

TABLE 29 (continued)

Variable	Responses			Total %
	Agree %	Disagree %	Undecided %	
POLITICAL PARTY				
Democrat	81.6	0	18.4	100 (N = 49)
Republican	90.4	2.4	7.2	100 (N = 42)
Independent	92.3	0	7.7	100 (N = 13)
Other	50	50	0	100 (N = 2)
POLITICAL EXPERIENCE				
4 Years or Less	90.9	0	9.1	100 (N = 33)
5-8 Years	88.4	2.3	9.3	100 (N = 43)
9-12 Years	74	6.7	19.3	100 (N = 15)
13-20 Years	66.7	0	33.3	100 (N = 9)
21 Years or More	100	0	0	100 (N = 6)
EDUCATION LEVEL				
12 Years of School or Less	90.9	0	9.1	100 (N = 35)
1-4 Years of College	87	0	13	100 (N = 21)
5 Years or More of College	82	4	14	100 (N = 50)

no responses were designed to determine whether or not each participant felt that the cost factor was an important consideration, in the event that the subject disagreed with the particular statement to any extent. Almost no respondent circled the "yes-no" designations on the opinionnaire provided. This made it impossible to include this variable in the subsequent analysis of the data.

VI. SUMMARY

In this chapter the researcher has examined in detail the responses of legislators, members of the State Board of Education, and local school board chairpersons to matters pertaining to health education programs and their possible implementation in the secondary school. Four general areas were examined. These included the health content of the health curriculum, the various kinds of potential health services to be provided, health practices, and a general statement about the practical utility of health education programs in dealing with health-related problems.

A brief recapitulation of the highlights of each section examined is in order. First, those health content areas deemed as most important by most respondents included first aid, food/nutrition, and physical and dental health. Low priority was given to such topics as death education, sex education, and marriage and parenting.

Second, focusing upon the area of health-related

services in the secondary school, almost all respondents gave significant consideration to the provision of school nurses and health committees. These services included first aid training and instruction in emergency medical services to deal with frequent accidents that are routinely encountered by teachers in the classroom and on the playground.

It was not particularly desirable to offer the services of physicians to each school. Free school lunches were also given minimal consideration by these respondents. It is likely that these services are increasingly cost-prohibitive and simply not economical as schools tend to move toward more austere educational programs.

Third, regarding health practices, most respondents felt inclined to endorse more inservice teacher training, better planned health education programs, and a greater emphasis upon the practical implications of such programs for the lifestyles of affected students.

Finally, respondent reaction to the notion that a good health education program should be designed to reduce health-related problems of persons served was highly favorable. Receiving low priority or minimal consideration were the ideas of expanding the senior high health course from one semester to two semesters and requiring that persons who teach health courses be certified with a major in health education.

In the following chapter, several general conclusions and recommendations will be presented.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

Purpose of the Study

The purpose of this study was to analyze and assess the health education needs of students in the public secondary schools of Tennessee as perceived by Tennessee legislators, State Board of Education members, and local school board chairpersons.

Importance of the Study

In the history of education in Tennessee, the Legislature has administered the legal apparatus through which local public school systems function. The Legislature provides monies, basic guidelines for teachers' salaries, certification requirements for instructional personnel, and deals with questions concerning curriculum. The Legislature generates basic educational policies and establishes financial systems and appropriations. The State Board of Education, created by legislation, has the responsibility of developing specific educational policies designed to reflect the basic policies set forth by Legislature. The State Board of Education advises the Legislature on various educational programs and the local school boards that operate these programs. The local school boards implement all programs within certain

boundaries established by the State. Therefore, these three groups jointly perform the role of determining school health education policies in Tennessee.

Health education has been cited by several critics as one of the most frequently neglected areas of instruction in Tennessee public schools. Also, relatively little has been done in recent years to foster a curriculum to meet more adequately student needs and interests.

Political position, experience, affiliation, education, sex, age, and residence categories were variables investigated. Specifically, the study sought to answer the following questions:

1. What are the health education needs of students in the Tennessee public secondary schools as perceived by legislators, members of the State Board of Education, and local school board chairpersons?
2. Is there a difference in the needs as perceived by the Tennessee legislators and as perceived by the members of the State Board of Education, and as perceived by the local school board chairpersons?
3. What areas of the school health education program are these policymakers in agreement and disagreement?
4. What issues of the school health education program do policymakers perceive as most important and least important?

5. What needs in school health education do policy-makers perceive as favorable and unfavorable?
6. Is there a relationship between what the policy-makers perceive as student health education needs and related characteristics such as age, sex, education, years of political experience, political affiliation, or residence?

Methodology

The target population for this study consisted of all State legislators, all members of the State Board of Education, and all local secondary school board chairpersons in Tennessee. An opinionnaire was developed (see Appendix B), pretested, using a small sample of school board members in Hamblen County, Tennessee, and then mailed to the entire population (i.e., 126 State legislators, 16 members of the State Board of Education, and 126 local secondary school Board chairpersons throughout Tennessee). Of the 268 opinionnaires mailed, 106 persons responded (40 percent). The opinionnaire consisted of seven descriptive items, 18 health content items, eight items pertaining to health services, 13 items on health practices, and one item that concerned health education in general. The responses were recorded on computer data cards. These data were then classified according to the independent variable of political position, age, sex, years of political experience, education level, political affiliation, and residential

background. Tests of significance and measures of association used in subsequent data analysis included the Kendall's coefficient of concordance, Spearman's Rho, chi-square, and the t test.

The level of significance was set at .05 for evaluating subsequent observed association between variables and differences between groups.

II. RECAPITULATION OF THE MAJOR FINDINGS

A description of the sample of 106 respondents revealed that most were males (91.5 percent) with an average age of 48 years. Almost all participants had at least a high school education, with nearly one-half having completed four or more years of college. Nearly 70 percent of these persons had over six years of political experience in educational matters, and about one-half were from rural residential origins. No respondents evidenced that they had ever attended a vocational or technical school.

The major independent variables used in the present research included sex, years of experience, level of educational attainment, political party affiliation, residential background, age, and years of political experience as either legislators or school board members.

Each of these variables were used to determine whether or not differences existed in matters pertaining to health education curriculum content, services, health-related

practices, and the development of a good health education program generally.

The findings of this research are summarized as follows:

1. There were no differences among the Tennessee legislators, members of the State Board of Education, and local school board chairpersons toward health content, services, and practices.
2. A significant relationship existed between males and females in their perceptions of health content, service, and practices.
3. Regardless of where the population resided, there were no differences among residents in their perceptions of health content, service, and practices.
4. There were no differences among the various political experience categories in their perceptions of health content, service, and practices.
5. Regardless of the level of education attained, there were no differences among the various categories in their perceptions of health content, service, and practices.
6. There were no differences among the various age categories in their perceptions of health content, service, and practices.
7. Political party affiliation categories did not perceive health content, service, and practices differently.

8. Political party affiliation categories did not perceive health content, service, and practices differently.
8. Health content areas of first aid, food/nutrition, physical, and dental health were perceived as most important by all respondents regardless of age, sex, education, position, experience, political affiliation, or residence.
9. Establishing a health committee and providing a nursing service were perceived as most important by all respondents regardless of age, sex, education, position, experience, political affiliation, or residence.
10. Health practices such as developing a better planned health education program and improving teacher inservice were perceived as most important by all respondents regardless of age, sex, education, position, experience, political affiliation, or residence.
11. There was almost unanimous support for the idea that a sound health education program should be designed to reduce health-related problems.
12. Regardless of the salient variables, health content areas of death education and sex education were perceived by most respondents as least important.
13. Regardless of the salient variables, health services

relating to free school lunches and the provision of physicians for each school were perceived by most respondents as least important.

14. The requirement of health teachers being certified and expanding the health course from one semester to two semesters in high school were health practices perceived by most respondents as least important.

III. CONCLUSIONS

On the basis of the findings the following conclusions were drawn:

1. Legislators, members of the State Board of Education, and local school board chairpersons in the State of Tennessee are concerned about the health needs of the students in secondary school systems. (Forty percent of the population responded to the opinionnaire.)
2. Legislators, members of the State Board of Education, and local secondary school board chairpersons are in agreement as to their perception of school health content, services, and practices.
3. Health content areas of first aid, food/nutrition, physical, and dental health are most important and death education, sex education, and health/life insurance are least important as perceived by the respondents.

4. Respondents perceived the establishment of health committees and providing nursing care as most important and the provision of school lunches and physician care as least important.
5. When identifying needs in school health education, respondents were not supportive of expanding health education from one semester to two semesters nor requiring certified teachers; however, respondents were supportive of a planned health education program and improving teacher inservice training.
6. Regardless of the socio-demographic variables, respondents did not perceive health content services or practices differently.

IV. RECOMMENDATIONS

The following recommendations are presented:

1. A health committee, consisting of school personnel, representatives from the community and from local health services, and health teachers should be established and assigned advisory responsibilities in conjunction with local school health programs. This was perceived by most respondents as an important health service.
2. In view of the participant's responses, local school board chairpersons appear to be slightly more concerned about secondary school health

education programs compared with either legislators or members of the State Board of Education. Therefore, it might be feasible for school health teachers to cultivate a better relationship with local school board members in the future.

3. Graduates who have a major in school health should give important consideration to the idea of running for political offices, especially those connected with the various health education programs in Tennessee.
4. Secondary school health education teachers who have been certified in first aid, emergency services for injury, sudden illness, and for disasters should provide inservice training to other teachers and help to organize such programs for the schools.
5. Secondary school health education programs are somewhat less likely to substantially receive fiscal or political support from the legislators and members of the State Board of Education. Thus, health educators might do well to focus their lobbying effort on local school board members.
6. School health teachers should exert every possible effort to keep school boards and legislators informed as to the importance of health in the curriculum. Therefore, studies should perhaps be conducted in other states and the results

distributed to legislators and Board of Education members on a regular basis.

CHAPTER VI

EPILOGUE

The purpose of this study was to analyze and assess the health education needs of students in the public secondary schools of Tennessee as perceived by the State legislators, members of the State Board of Education and local school board chairpersons in Tennessee. This task was accomplished in part, by designing an opinionnaire to gather the necessary information, pretesting the instrument, and administering it to 126 legislators, 16 members of the State Board of Education, and 126 local secondary school board chairpersons. The data were subsequently tabulated and analyzed in an effort to determine respondent sentiments toward a variety of health-related topics.

Given the fact that educational issues at virtually any grade level throughout the State are often controversial ones and are frequently the subjects of political debates and confrontations, it was originally believed that some differences would be found to exist between respondents representing various political interests. Interestingly enough, no substantial differences were observed to occur between persons on the State Board of Education, Legislature, or local school. This was somewhat surprising.

It was also believed that persons of different residential backgrounds or of differing ages would likely be

divided in their opinions about the preferred content of health-related courses, health services, and practices. Again, no differences of any consequence were observed. There was, in fact, a remarkable set of strong correlations throughout the entire study evidencing the fact that regardless of the independent variable used, persons surveyed were in accord with respect to their opinions about the importance (and unimportance) of health course content, service, and practices.

Perhaps the greatest strength of the present study was to illustrate the fact that a common ground exists for approaching and dealing with health-related educational problems among persons representing varying political interests and from diverse backgrounds. This should be regarded as a positive sign to persons attempting to develop and implement health-related educational programs throughout the State of Tennessee. While it is likely that competition will occur between different persons and agencies developing innovative health education programs for adoption consideration by the State, there does at least appear to be tacit support among these respondents for hearing proposals for such programs.

Another positive feature was the fact that several areas of health education were clearly delineated as "preferred" content areas for health courses, or specific services, or health practices. This will be of significant value to

program developers as they plan their individual health education projects and curriculums. At least, they will now have a preliminary indication of what "significant others" feel about the inclusion or exclusion of various topics and services.

In some respects, it was puzzling to see low priority assigned to topics such as sex education and marriage and parenting. While we can probably appreciate the fact that death education is not a particularly "lively" topic to introduce in the secondary school curriculum, it is difficult to understand fully the reasons for why these respondents did not place greater emphasis on sex education. Rising rates of venereal disease and illegitimacy among teenagers would seem to suggest that greater attention be given to this topic, particularly in the secondary school. Of course, sex education is a politically sensitive issue. It may very well have been the case that these persons were simply sidestepping the political and moral problems of implementing sex education in the schools by assigning it relatively low priority compared with other health-related topics.

Considering the very nature of their backgrounds, it was thought that urban persons might be more liberal in their views toward health education and, therefore, they would be likely to take stand on health-related issues opposite those persons with rural origins. However, there was a high degree of agreement between the urban and rural groups on such

issues as sex education, marriage and parenting, and death. Both urban and rural groups consider these subjects the least desirable health content areas. It should be noted that urban aggregate ranked driver education more important as compared to rural counterparts. This could be attributed to the fact that urbanites are more concerned about resolving traffic problems of the larger city. One approach to reducing traffic problems is to have better educated drivers. A sound health education program featuring such a content area as driver education would be consistent with achieving this objective.

Another finding was that rural respondents tended to emphasize the importance of physical activity and play to a greater degree than urban respondents. This might be accounted for by the fact that rural dwellers perform or are expected to perform more physical chores and engage in more demanding physical activities as contrasted with their urban-suburban counterparts.

Finally, rural and suburban respondents emphasized first aid to a greater degree than urban respondents. The fact that numerous farm accidents occur each year and physician assistance is often seriously delayed in rural areas could account for this difference in ranking.

Although the differences were not significant between different age groups toward health issues, those older persons (59 years of age and older) placed less emphasis on

the alcohol/drug abuse and tobacco use areas compared with those younger persons. No information was available to enable the researcher to ascertain which respondents were smokers/nonsmokers or drinkers/nondrinkers. One explanation for this difference may be that the older segment of respondents are less concerned with the detrimental effects of alcohol and tobacco because they are living examples of persons who have "survived" in spite of what health educators have said about alcohol and tobacco consumption.

It is perhaps suggestive of the times that most of these participants considered equally important the idea that school health education should be taught in a manner that students can apply it to their particular lifestyle (e.g., dieting, personal hygiene, etc.). This has a strong utilitarian emphasis, where persons are (or at least seem to be) increasingly concerned with obtaining something tangible for their tax dollars and educational expenditures. Maintaining the status quo in health education seemingly may be a present situation that has plagued other courses in public education as well as plagued educational institutions. Accountability and cost-effectiveness has not been new to the field of health planning, however, its application to all public education reflect the reality of the situation.

Since many health content areas were perceived favorably, it was expected that respondents would perceive the need to expand the health course from one semester to two semesters.

However, it was assigned low priority. Financial cost may be the obstacle that prevents the semester expansion.

Overall, the impression left from general responses was that health education programs would be desirable if they were well planned, designed to relate to real life experiences of students, and appealed to more practical health-related concerns such as reducing disease, poor mental health, and personal injury.

It is clear that these respondents were not supportive of the practice to require teachers of health education courses to be certified with a major in health education. Paradoxically, respondents expressed the need for a quality well-planned, comprehensive health curriculum to be implemented by uncertified teachers.

In conclusion, it is not a matter of whether one is a Democrat or Republican, highly educated or less educated, urban or rural, male or female, young or old, politically experienced or inexperienced, or legislator, member of the State Board of Education, or local secondary school board chairperson that will determine the objectives and direction of health education programs in secondary schools. Most decision-makers will be guided by the principle of financial expediency and by utilizing criteria for evaluating health programs that include practical and economical considerations. We may be witnessing the gradual disappearance of programs and services that are luxuries and that benefit a

minority. Those programs with the most general application and that have most obvious utilization for the majority and its health-related problems will be increasingly retained. Ultimately, it will be up to the health educator to take a leading role in implementing changes in current secondary school health education curriculums throughout the State. A local approach involving the local school board members and the community, through committee participation, appears to be an appropriate and advantageous avenue to take.

BIBLIOGRAPHY

BIBLIOGRAPHY

1. Adams, David. "A Study of Health Instructional Programs in the Public Secondary Schools in Tennessee." H.S.D. Indiana University, 1974.
2. Alexander, Carter. Publicity Campaigns for Better School Support. Yonkers-on-Hudson, New York: World Book Co., 1921, pp. v-161.
3. Ast, David B. "Prevention and the Power of Consumers." American Journal of Public Health 68(1):15-16, January, 1978.
4. Barnes, Robert C. and Valorie E. Nybo. "Health Classes Can Change Personal Health Behavior." Health Education 9(4):23-25, July-August, 1978.
5. Bell, James C. "Attitudes Toward Items in the Professional Negotiations Process as Expressed by Kentucky School Board Chairpersons and Teacher Association Presidents" (Unpublished Ed.D. Dissertation, University of Kentucky, 1977).
6. Bervaldi, Paul E. "Perceptions of Florida Educators and School Board members Regarding the Impact of School Integration on the Academic Gains and Social Acceptance of Negro Children" (Unpublished Ed.D. Dissertation, The Atlantic University, 1978).
7. Brill, Harry. Why Organizers Fail. The Story of a Rent Strike. Berkley, California: University of California Press, 1971, pp. 1-192.
8. Byler, Ruth V., Gertrude M. Lewis, and Ruth J. Totman. Teach Us What We Want To Know. New York: Connecticut State Board of Education, 1969, pp. v-179.
9. Castile, Anne S. and Stephen J. Jerrick. "School Health in America: A Survey of State Health Programs." American School Health Association. Kent, Ohio, 1976, pp. i-98.
10. Candoli, I. Carl. School Business Administration: A Planning Approach. Boston: Allyn & Bacon, Inc., Second Edition, 1978.
11. Chambers, Clarke A. Paul U. Kellogg and the Survey: Voice For Social Welfare and Social Justice. Minneapolis, Minnesota: University of Minnesota Press, 1971, pp. 1-283.

12. Champion, Dean J. Basic Statistics for Social Research. Chandler Publishing Co., 1981, pp. 13-14, 147-150.
13. Chase, Darrell. "Health Education in Rural Appalachia." Health Education 9(3):14-15, May-June 1978.
14. Chass, Baruch. "An Analysis of Perceptual Differences Among the U.S. Olympic Committee Executive Board Members, Athletes' Representatives, and Coaches" (Unpublished Ph.D. Dissertation, Ohio State University, 1978).
15. Church, Albert M. "The North Carolina Teacher Tenure Act As Perceived by Superintendents, Selected School Board Members, and Selected Principals" (Unpublished Ed.D. Dissertation, Duke University, 1978).
16. Cistulli, Joseph V. "The Perceptions of Legislators, Advisory Council Members, Administrators, and Faculty Towards Three Aspects of Community Services in Public Two-Year Colleges" (Unpublished Ph.D. Dissertation, University of Connecticut, 1977).
17. Colman, Charles K. "A Study to Determine the Extent to Which Selected Florida Educators, Community Leaders, and Legislators Agree On What Should Constitute Minimum Basic and Functional Skills Required for Secondary School Graduation" (Unpublished Ed.D. Dissertation, Florida Atlantic University, 1978).
18. Cornacchia, Harold J. "Guidelines for Secondary School Health Education." Health Education, pp. 22-24, May-June 1975.
19. Croskery, Beverly Ann F. "A Study to Determine the Attitudes of Clergy, School Board Members, and Elementary Teachers Toward Death Education In the Schools" (Unpublished Ph.D. Dissertation, University of Toledo, 1978).
20. Deciding What To Teach. Project on the Instructional Program of the Public Schools. Washington, D.C.: National Education Association, 1963, pp. 86-101.
21. Dorsch, Gerald Duane. "Health Education in Kansas Public Schools, Grades One Through Twelve, and Public and Private Institutions of Higher Learning" (Unpublished Ph.D. Dissertation, Kansas State University, 1971, abstract).

22. Dowell, Linus J. "The Relationship Between Knowledge and Practice." The Journal of Educational Research 62(5):210-215, 1969.
23. Dratz, John P. "A Comparative Survey of Health Education in Public Secondary Schools in Selected Sections of the United States" (Unpublished Ph.D. Dissertation, State University of Iowa, 1952, abstract).
24. Easton, David. A Systems Analysis of Political Life. New York: John Wiley & Sons, 1965.
25. Eatwistle, Noel. Strategies for Research and Development in Higher Education. Amsterdam: University of Lancaster, Department of Educational Research, Swets & Zeitlinger Publishers, 1976.
26. Else, Harlan E. "Iowa Teachers, Superintendents, and Board Members Expected Outcomes of the Iowa Public Employment Act" (Unpublished Ph.D. Dissertation, Iowa State University, 1977).
27. Febel, Fredrich. "Parental Opinion Survey of Health Education on the Secondary Public School Level" (Unpublished Doctoral Dissertation, Indiana University, 1954).
28. Forward Plan for Health, 1978-82. Washington, D.C.: Department of Health, Education, and Welfare, Office of Assistant Secretary for Health, Government Printing Office, August, 1975.
29. Funk, Fanchon F. "Health Attitudes and Practices in An Isolated Appalachian Valley" (Unpublished Ed.D. Dissertation, The University of Tennessee, Knoxville, June, 1970, Abstract).
30. Gaddis, James. Superintendent of Morristown City School System, Personal Interview on October 31, 1978.
31. Galli, N. "Foundations of Health Education." Journal of School Health, pp. 158-165, March 1976.
32. Gaynor, Alan K. "Some Implications of Political Systems Theory for Alternative Demand Processing Mechanisms for Public School Systems." Educational Administration Quarterly 7(1):34-45, Winter 1971.
33. Gholston, Santee. "The Perceptions of Teachers, Parents, and Students Toward Year-Round Education in Selected High Schools of Memphis, Tennessee" (Unpublished Ph.D. Dissertation, Southern Illinois University, 1977).

34. Gilbert, Neil and Harry Specht. "Process Versus Task in Social Planning." Social Work 22(3):178-183, May 1977.
35. Goodlad, John I. The Changing School Curriculum. New York: The Georgian Press, Inc., 1966, pp. 85-91.
36. Goldsmith, Francis J. and Godfrey M. Hochbaum. "Changing Peoples' Behavior Toward the Environment." Public Health Reports 90(3):231-234, May-June 1975.
37. Hamrick, Michael H. "A Comprehensive Evaluation of the Status of the School Health Education Program in Bedford County, Tennessee" (Unpublished Ed.D. Dissertation, The University of Tennessee, June 1973, pp. iii-299).
38. Hanna, Ira R. "An Analysis of the Perceptions of Virginia School Superintendents and School Board Chairpersons Concerning the Role of the Superintendent of Schools in Collective Negotiations" (Unpublished Ed.D. Dissertation, College of William and Mary in Virginia, 1977).
39. Harrison, Laura H. "Perceptions of Utah School Board Members Relative to Title IX" (Unpublished Ed.D. Dissertation, Brigham-Young University, 1977).
40. Hasson. "Elementary Principal Support Behavior as Perceived By Teachers and Subordinates" (Unpublished Ed.D. Dissertation, 1977).
41. "Health Education Conference Geneva Park, April 25, 1975." Journal of the Canadian Association for Health, Physical Education, and Recreation 41(5): 3-7, Ottawa, Ontario, May-June, 1975.
42. Hearn, Edell M. "Public Educational Changes Through Legislation in Tennessee, 1935-1959" (Unpublished Ed.D. Dissertation, The University of Tennessee, 1959, pp. iii-394).
43. Hoffman, Earl E. "An Historical Study of Legislation for General State Aide to School Districts and the Relationships Between Personal Characteristics and Voting Behavior of Wisconsin Legislators With Special Emphasis on the Period 1947-1950" (Unpublished Ph.D. Dissertation, University of Wisconsin, 1964).

44. Holcomb, Ruth A. "A Survey of State Health Departments' Hiring Policies and Job Specifications for Community Health Educators" (Unpublished Master Thesis, University of Illinois, 1972, pp. 1-54).
45. Huntsinger, Phillip G. "The Status of Health Instruction in the Public Schools of Tennessee" (Unpublished Ed.D. Dissertation, The University of Tennessee, August 1971, pp. ii-158).
46. Hurley, Phil C. "Perceptions of Missouri School Board Presidents Concerning Relative Importance of Selected School Programs and Services" (Unpublished Ed.D. Dissertation, St. Louis University, 1977).
47. Jeremiah, Mary Alyce. "Ohio School Health Education Study: Status of the School Health Instructional Program in Ohio's Public Secondary Schools" (Unpublished Ed.D. Dissertation, Ohio State University, 1973, pp. 1-93).
48. Jobe, Martha P. "The Opinions of the Mississippi Legislators' Identified Public Toward the Establishment of Public Kindergarten in the State of Mississippi" (Unpublished Ph.D. Dissertation, University of Mississippi, 1978).
49. Johnson, Leslie H. "The Attitudes of Selected Mississippi Public School Teachers, Principals, Superintendents, and School Board Members Toward the Concept of Educational Accountability" (Unpublished Ed.D. Dissertation, Mississippi State University, 1977).
50. Kennedy, Virginia C. "Interpreting Legislature Voting Patterns on Health Issues: A Method and Rationale." Journal of Community Health 1(3):188-195, Spring 1976.
51. Kennison, James L. "A Study of the Health Instructional Programs Offered in Selected Junior and Senior High Schools in the Commonwealth of Kentucky" (Unpublished Ed.D. Dissertation, University of Kentucky, 1965, Abstract).
52. Knutson, Andie L. "Application of Pre-Testing in Health Education." Public Health Monographs 8:1-10, 1953.
53. Kushner, Harvey W. "Electoral Margins and Ideological Voting." Public Data Use 3(3):23-27, July 1975.

54. Lasch, Henry A. "A Survey of Health Education Needs in New Jersey" (Unpublished Ed.D. Dissertation, University of Ohio, 1972).
55. "Legislative Master Planning: The California Experience." Planning for Higher Education 3(1):1-4, February 1974.
56. Levy, Marvin R. "A Study of Health Instructional Practices in New Jersey Public Secondary Schools" (Unpublished Ed.D. Dissertation, Columbia University, 1969, Abstract).
57. Lewis, James J. Critical Issues in Education: A Problem-Solving Guide for School Administrators. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1972, pp. 125-172.
58. Liddell, Lewis. "A Comparison of Attitudes Toward Music Education Among School Board Members, Presidents, Superintendents, Principals, and Music Teachers in Mississippi Public Schools" (Unpublished Ed.D. Dissertation, Mississippi State University, 1977).
59. Manthey, Carl W. "The Present Program and Practice in Health Education in Selected Public High Schools With Recommendations for Improvement in the Lincoln Senior High Schools" (Unpublished Ed.D. Dissertation, University of Nebraska Teachers College, 1962, Abstract).
60. Manual for County Education Association of the Tennessee Education Association (For Use in Planning and Developing a Program for Professional Activities). Nashville: Tennessee Education Association, 1941, pp. 22-23).
61. Martin, Floride M. "A Comparative Study of the Educational Needs of a Community as Identified by Selected Groups Having Influence Within the Community to Those Needs Identified by Board of Trustees and Administrators of the School District" (Unpublished Ed.D. Dissertation, University of South Carolina, 1977).
62. Mazzoni, Tim L. and Roald F. Campbell. "Influentials in State Policy-Making for the Public Schools." Educational Administration Quarterly 12(1):1-26, Winter 1976.

63. Means, Richard K. "The School Health Education Study: A Pattern in Curriculum Development." Journal of School Health 36(1-2), January 1966.
64. Meigs, Return J. and William F. Cooper. The Code of Tennessee. Nashville: E.G. Eastman & Co., State Printers, 1858 (TCA 1019).
65. Michie, A.H. Michie's Tennessee Code of 1938. Charlottesville, Virginia: The Michie Co., Law Publishers, 1938 (TCA 5763-5805).
66. Michie, A.H. Michie's Tennessee Code of 1938, Complete Annotations. Charlottesville, Virginia: The Michie Co., Law Publishers, 1938 (TCA 2423; 2715).
67. Mico, Paul R. "An Introduction to Policy for Health Educators." Health Education Monographs 6(1):7-18, 1978).
68. Miller, Delbert C. Handbook of Research Design and Social Measurement. New York: David McKay Co., Inc., 1970, pp. 66-139.
69. Miller, Van. "Power, People, Principals." The National Elementary Principal 41(4):40-45, January 1962.
70. Milliken W.A. and John J. Vertrees. The Code of Tennessee. Nashville: Marshall & Bruce, Printers & Publishers, 1884, p. 228.
71. Milstein, Mike M. and Robert E. Jennings. "Educational Interest Group Leaders and State Legislators: Perceptions of the Educational Policy-Making Process." Educational Administration Quarterly 9(1):54-70, Winter 1972.
72. Nachatilo, William R. "The Educational Cooperative Service Unit as Perceived by School Board Presidents, Administrators, and Teachers in Planning Regions One and Two of Northwestern Minnesota" (Unpublished Ed.D. Dissertation, University of North Dakota, 1977).
73. Ness, Paul F. "Forces and Techniques Which Influence Educational Legislation in Colorado" (Unpublished Ed.D. Dissertation, Colorado State College, 1966).
74. Nie, Norman H. Statistical Package for the Social Sciences. New York: McGraw-Hill Publishing Co., 1975.

75. Nolin, Reginald S. "Perceptions of Parents, Teachers, School Administrators, and School Board Members With Regard to the Role of the Elementary Schools" (Unpublished Ed.D. Dissertation, Northern Illinois University, 1977).
76. Orr, Oscar P. "An Evaluation of Health Interests and Health Education Needs as Basic Premises in Selecting Health Content in the Secondary Schools of Knoxville, Tennessee" (Unpublished Ed.D. Dissertation, The University of Tennessee, 1965, pp. ii-276).
77. Owens, Mitchell V. "How Legislative Resolutions Stimulate Positive Action." Health Education, pp. 21-22, March-April 1975.
78. Opportunities for An Improved Program of Public Education in Tennessee. A report of the work of the State Conference on Public Education for School Superintendents, Principals, Supervisors, and Teachers, held in Knoxville, July 14-26, 1946.
79. Parten, Mildred. Surveys, Polls, and Samples: Practical Procedures. New York: Harper & Bros. Publishers, 1950, p. 94.
80. Peterson, Paul E. School Politics Chicago Style. Chicago, Illinois: University of Chicago Press, 1976.
81. Peile, Phillip K. and John S. Hall. Budgets, Bonds, and Ballots. Lexington, Massachusetts: Lexington Books, D.C. Heath Co., 1973, pp. 71-122.
82. Phillips, Arthur A. "The Attitude of the Sixty-Fourth Texas Legislators Towards Serving the Severly and Profoundly Handicapped and Handicapped Infants Below the Age of Three (Unpublished Ed.D. Dissertation, North Texas State University, 1977).
83. Pressly, Velma. "Study of Health Education Status in Tennessee" (Unpublished Ed.D. Dissertation, The University of Tennessee, February 1979).
84. Prindle, Delbert A. "A Study to Determine the Rights of Superintendents and Principals As Perceived By Board of Education Members, School Administrators, and Teachers of Class III Public School Districts in the State of Nebraska" (Unpublished Ed.D. Dissertation, University of Nebraska, 1977).

85. Radin, Norma. "A Personal Perspective on School Social Work." Social Casework, pp. 605-613, December 1975.
86. Raider, Melvyn C. "An Evaluation of Management by Objectives." Social Casework, pp. 79-83, February 1975.
87. Raser, John R. Simulation and Society, An Exploration of Scientific Gaming. Boston: Allyn & Bacon, Inc., pp. 124-136, 1969.
88. Reizen, Maurice S. "Policy Development & Implementation Issues for Health Education." Health Education Monographs 6(1):74-90, 1978.
89. Rieselbach, Leroy. People Vs. Government. Bloomington: Indiana University Press, 1976.
90. Rules, Regulations, and Minimum Standards (1979-80). Tennessee State Board of Education, State Board of Vocational Education, Nashville, Tennessee, July 1979.
91. Schwich, Luther C. and Travis Clark. "A Pilot Project in Bermuda." Health Education 9(4):29-30, July-August 1978
92. Shannon, Robert T. Annotated Code of Tennessee. Nashville: Marshall & Bruce Co., Law Publishers, 1896 (TCA 3103, 1455, 1456).
93. Shannon, Robert T. Annotated Code of Tennessee, Supplement of 1926. Indianapolis, Indiana: The Bobbs-Merrill Co., Publishers, 1926 (TCA 2418, 2397, 2381, 2343).
94. Shannon, Robert T. Supplement to Shannon's Code. Nashville, Tennessee: Marshall & Bruce Co., Publishers, 1896 (TCA 1401-1487).
95. Shirreffs, Janet H. "Investigating the Meaning of Health and the Scope and Nature of Health Education." Health Education 9(1):22-24, January-February, 1978.
96. Shockley, J.B. Hamblen County State Representative, Personal Interview on October 20, 1978.
97. Simonds, Scott K. "Health Education as Social Policy." Health Education Monographs 2(1):1-10, 1974.

98. Sinacore, John S. "A Study and Evaluation of the Health Education Programs of the Secondary Schools of Suffolk County, Long Island, New York" (Unpublished Ed.D. Dissertation, New York University, 1956), Abstract).
99. Skogberg, Alfred H. Administrative Operational Patterns. New York: Teachers College, Columbia University, Bureau of Publications, 1950, pp. 24-43.
100. Sliepcevich, Elena M. School Health Education Study 1961-63, A Summary Report. Washington, D.C., 1964, pp. 1-74.
101. Smith, Barbara Leigh. "Political Party as an Indicator of Educational Posture in Oregon." Educational Administration Quarterly 10(3):80-100, Autumn 1974.
102. Smith, Charles E. "A Survey and Comparison of Attitudes Held by the Tennessee General Public and State Legislators Toward Higher Education" (Unpublished Ph.D. Dissertation, George Peabody College for Teachers, 1976, pp. iii-145).
103. Steger, Thomas M. and Seymour D. Thompson. A Compilation of the Statute Laws of the State of Tennessee. Vol. II, Saint Louis, Missouri: W.J. Gilbert, Law Book Publishers, 1873 (TCA 5508-1207).
104. Tennessee Blue Book 1979-80. Compiled and edited by Dana-Ford Thomas, State of Tennessee.
105. Tennessee Directory of Public Schools (1978-79). Nashville, Tennessee: State Department of Education.
106. Tennessee Public Acts 1951. Nashville: Rich Printing Co., 1951 (House Bill #85).
107. Tennessee Public Acts 1957. Nashville: Rich Printing Co., 1957.
108. Tennessee Public Acts 1969. Nashville: Curley Printing Co., 1969 (Senate Bill #656).
109. Tennessee Public Acts 1972. Nashville: Rich Printing Co., 1972 (Senate Bill #1686, 1394, 1206).
110. Tennessee Public Acts 1975. Nashville: Rich Printing Co., 1975 (House Bill #504).

111. The Code of Tennessee 1932. Kingsport, Tennessee: Southern Publishers, Inc., 1932.
112. The Code of Tennessee 1934. Charlottesville, Virginia: The Michie Co., Law Publishers, 1934 (TCA 2339, 2314).
113. The Rhode Island School Health Education Study: A Summary Report of a Research Project. Rhode Island: Department of Education, 1969, pp. 6, 32-33.
114. Thomas, Norman C. Education in National Politics. New York: David McKay Co., Inc., 1975, pp. 3-18.
115. Thompson, Francis C. "Public and Legislature Survey of Louisiana Educational Problems: An Opinion Measurement and Descriptive Study" (Unpublished Ed.D. Dissertation, Northeast Louisiana University, 1977).
116. Thompson, John T. Policymaking in American Public Education: A Framework for Analysis. Englewood Cliffs, New Jersey: Prentice-Hall, 1976, pp. 1-278.
117. Tittle, Charles R. and Richard J. Hill. "Aptitude Measurement and Prediction of Behavior: An Evaluation of Conditions and Measurement Techniques." Sociometry 30, 1967.
118. Tones, B.K. "Health Education: Problems and Prospects." Community Health 7(1):2-7, July-August 1975.
119. Unruh, Glenys G. and Robert R. Leeper. Influences in Curriculum Change. Washington, D.C.: National Education Association, 1966, pp. 100-116.
120. Usdan, Michael, David Minar, and Emanuel Hurwitz, Jr. Education and State Politics. Ithaca, New York: Teachers College Press, 1969.
121. Vann, James E. "North Carolina Legislators' Perception of the North Carolina Community College System" (Unpublished Ed.D. Dissertation, University of North Carolina, 1970).
122. Veenker, C.H. "Results of Measuring Knowledges, Attitudes, and Practices of School Age Children. Synthesis of Research in Selected Areas of Health Instruction." School Health Education Study. Washington, D.C., 1966.

123. "Voter Behavior and Campaign Strategies in School Finance Elections.: Educational Research Service, Inc. Arlington, Virginia, 1977, pp. 35-42.
124. Waggoner, Diana R. "The Oregon School Health Education Study" (Master Thesis, University of Oregon, 1971, Abstract).
125. Walker, Katheleen F. "Attitudes and Perceptions of the Louisiana Legislature (1977) Concerning the Louisiana Cooperative Extension Service" (Unpublished Ed.D. Dissertation, Louisiana State University, 1977).
126. Weingarten, Victor. "Report of Findings and Recommendations of the President's Committee on Health Education." Health Education Monographs 2(1):11-19, 1974.
127. Williams, Jesse F., Clifford Brownell, and Elmon Vernier. The Administration of Health Education and Physical Education. Philadelphia: W.B. Saunders Co., 1966, pp. 287-299.
128. Winters, Robert J. "A Community Raises Its Consciousness." International Society of Educational Planners 3(2):24-26, Winter 1973-74.
129. Wright, James W. "A Study of School Board Members and Superintendents' Perceptions of Relationships, Roles, and Responsibilities in Selected School Districts of New Jersey" (Unpublished Ed.D. Dissertation, Rutgers University, 1977).

APPENDICES

APPENDIX A
CORRESPONDENCE

Rt. 4, Box 355C
Talbot, TN 37814

Dear

I am a doctoral candidate in the Division of Health and Safety at The University of Tennessee. Presently I am conducting research that will examine the perceptions of selected groups concerning health education experiences of Tennessee public secondary school students. These three groups consist of all legislators, all members of the State School Board, and all local school board chairpersons. This has been recognized as an important study by not only my doctoral committee, but also by some members of the three groups. Your participation in this study will help to improve the health education program in our schools.

I can assure you that your replies to the attached opinionnaire will be kept strictly confidential. You will not be identified.

Practically all of the statements can be answered with a simple mark, so it should not take more than 10 minutes of your time. Each statement will be of value in helping us to improve the health education program in Tennessee.

Please fill out the opinionnaire as soon as possible and return it in the enclosed self-stamped envelope. If you would like to receive a copy of my findings, please sign your name to the opinionnaire where indicated.

On behalf of the students, teachers, and Tennessee public secondary schools that may benefit from this research, thank you.

Sincerely,

Don Mitchell
Doctoral Candidate

Bill C. Wallace
Doctoral Advisory Committee
Chairperson

November 20, 1980

The Honorable Frank P. Lashlee
Chairman of Education Committee
149 Forrest Avenue
Post Office Box 504
Camden, Tennessee 38320

Dear Sir:

On November 12, 1980, I met with my friend, Representative J.B. Shockley in Morristown. We discussed a research project I am doing as required for my Doctoral Degree at The University of Tennessee. We believe the information gained from this research can help to improve the health education program in Tennessee Public Secondary Schools.

Enclosed you will find a copy of my questionnaire and an introductory letter that shall accompany it. Both shall be mailed to all legislators, State Board of Education members, and local board chairpersons in Tennessee. Representative Shockley and I feel that your endorsement on my cover letter should enhance response to the questionnaire.

I would very much appreciate your signing your name in the appropriate place if you are willing to help. If you would like more information about this project, please indicate.

Thank you for your cooperation.

Sincerely,

Don G. Mitchell
Doctoral Candidate
Route 4, Box 355C
Talbott, Tennessee 37877

DGM:vh

Enclosures

Rt. 4, Box 355C
Talbott, TN 37814

Dear Tennessee Board of Education Member:

I am a doctoral candidate in the Division of Health and Safety at The University of Tennessee. Presently I am conducting research that will examine the perceptions of selected groups concerning health education experiences of Tennessee public secondary school students. These three groups consist of all legislators, all members of the State School Board, and all local school board chairpersons. This has been recognized as an important study by not only my doctoral committee, but also by some members of the three groups. Your participation in this study will help to improve the health education program in our schools.

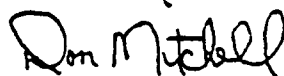
I can assure you that your replies to the attached opinionnaire will be kept strictly confidential. You will not be identified.

Practically all of the statements can be answered with a simple mark, so it should not take more than 10 minutes of your time. Each statement will be of value in helping us to improve the health education program in Tennessee.

Please fill out the opinionnaire as soon as possible and return it in the enclosed self-stamped envelope. If you would like to receive a copy of my findings, please sign your name to the opinionnaire where indicated.

On behalf of the students, teachers, and Tennessee public secondary schools that may benefit from this research, thank you.

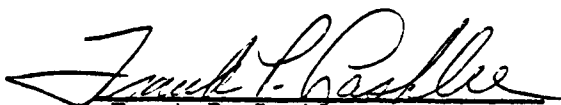
Sincerely,



Don Mitchell
Doctoral Candidate



Bill C. Wallace
Doctoral Advisory Committee
Chairperson



Frank P. Lashlee
Chairman of Education Committee

POSTCARD REMINDER

Dear

This is a reminder that two weeks ago an opinionnaire on secondary school health education content, services, and practices was mailed to you. Many people have already responded but a few have not. If you have returned your opinionnaire, thank you very much. If you have not completed it, please do so. Your input into this study is important and greatly appreciated.

Sincerely,

Don Mitchell
Doctoral Candidate
The University of Tennessee

APPENDIX B

OPINIONNAIRE

OPINIONNAIRE

Please sign your name if you would like to have a copy of the data.

I. Status of Information

Please indicate your response to each statement in this section by responding in the appropriate space. It's extremely important that each question be answered.

1. Your political position is:
 - a. legislator_____
 - b. state school board member_____
 - c. local school board member_____
 - d. legislator and local school board member_____
2. Your age is_____
3. Your sex is: a. male_____ b. female_____
4. Number of total years experience as a:
 - a. legislator_____
 - b. state school board member_____
 - c. local school board member_____
5. Circle the last year of school you completed in your formal education:

grade	jr. high	high school	college	graduate	business/trade
1 2 3 4 5 6	7 8 9	10 11 12	1 2 3 4	5 6 7 8	1 2 3 4
6. Your political affiliation is:
 - a. Democrat_____
 - b. Republican_____
 - c. Independent_____
 - d. Other_____
7. Your residence is: a. rural_____ b. suburban_____ c. urban_____

II. Health Content

Please circle the letter(s) on the right of each statement that indicates how you feel about each health content area being taught in Tennessee public secondary schools.

SA - Strongly Agree A - Agree U - Undecided D - Disagree SD - Strongly Disagree

- | | | | | | |
|---|----|---|---|---|----|
| 8. Structure and function of the body | SA | A | U | D | SD |
| 9. Food and nutrition | SA | A | U | D | SD |
| 10. Physical activity and play | SA | A | U | D | SD |
| 11. Rest, sleep, and relaxation | SA | A | U | D | SD |
| 12. Mental health | SA | A | U | D | SD |
| 13. Consumerism (selecting doctor, dentist, health insurance, etc.) | SA | A | U | D | SD |
| 14. Safety, disaster, and civil defense | SA | A | U | D | SD |
| 15. First aid | SA | A | U | D | SD |
| 16. Alcohol and substance abuse | SA | A | U | D | SD |
| 17. Smoking and use of tobacco products | SA | A | U | D | SD |
| 18. Disease prevention | SA | A | U | D | SD |
| 19. Health and life insurance | SA | A | U | D | SD |
| 20. Death education | SA | A | U | D | SD |
| 21. Driver education (motorcycle, bicycle, and automobile safety) | SA | A | U | D | SD |
| 22. Physical and dental health | SA | A | U | D | SD |
| 23. Dieting | SA | A | U | D | SD |
| 24. Sex education | SA | A | U | D | SD |
| 25. Marriage and parenting | SA | A | U | D | SD |
| 26. A good health education program should help reduce medical problems, medical costs, and help to prevent some diseases | SA | A | U | D | SD |

Additional comments_____

III. Health Services

Please circle the letter(s) on the right of each statement that indicates your opinion. If you disagree with any statement, indicate if your disagreement is due to cost (in yes-no column).

27.	School should provide for essential health services such as a free physical and dental examination.	SA	A	U	D	SD	Yes	No
28.	A health committee with a membership that includes school personnel, representatives from the community and health services, and the health teacher should be assigned advisory responsibilities for the local school health program.	SA	A	U	D	SD	Yes	No
29.	School nurses should be available in a ratio of 1 nurse (or more) for each 1,000-1,500 pupils.	SA	A	U	D	SD	Yes	No
30.	Physicians and dentists should be retained for consultation and advice.	SA	A	U	D	SD	Yes	No
31.	School lunches should be provided by the state and federal governments free to all students regardless of race or income.	SA	A	U	D	SD	Yes	No
32.	School buses should have seat belts installed as a safety measure.	SA	A	U	D	SD	Yes	No
33.	In an effort to reduce youth automobile fatalities, curb the consumption of gasoline, reduce the construction of school parking lots, and reduce traffic, the age for obtaining a driver's license should be raised from 16 years of age to 18 years of age.	SA	A	U	D	SD	Yes	No
34.	Each school district should employ a physician as directed under the school health program.	SA	A	U	D	SD	Yes	No

Additional comments _____

IV. Instructional Practices

SA - Strongly Agree A - Agree U - Undecided D - Disagree SD - Strongly Disagree

35.	Schools should provide for a comprehensive and well-planned program of health instruction.	SA	A	U	D	SD	Yes	No
36.	School health education should receive the same emphasis as other areas of instruction.	SA	A	U	D	SD	Yes	No
37.	School health education textbooks should be updated every five years.	SA	A	U	D	SD	Yes	No
38.	School health education should be a separate course.	SA	A	U	D	SD	Yes	No
39.	School health education should be taught as a part of other courses such as science, homemaking, and social studies.	SA	A	U	D	SD	Yes	No
40.	There should be a written plan of health instruction throughout all school grades.	SA	A	U	D	SD	Yes	No
41.	All school teachers should receive psychological examinations (as is required of school bus drivers and law enforcement officers).	SA	A	U	D	SD	Yes	No
42.	The junior high school health classes should be two semesters in length.	SA	A	U	D	SD	Yes	No
43.	There should be a planned program of evaluation to appraise the effectiveness of health instruction in terms of student growth in the understanding and attitudes.	SA	A	U	D	SD	Yes	No
44.	School health education should be taught in a manner that students are able to apply it to their lifestyle (i.e. dieting, personal hygiene, etc.)	SA	A	U	D	SD	Yes	No
45.	The senior high school health classes should be two semesters in length.	SA	A	U	D	SD	Yes	No
46.	Only teachers certified with a major in school health should instruct health education in school.	SA	A	U	D	SD	Yes	No
47.	Teachers should receive inservice training in the areas of first aid, emergency services for injury, sudden illness, and for disasters.	SA	A	U	D	SD	Yes	No

Additional comments _____

APPENDIX C

LIST OF PANEL MEMBERS

LIST OF PANEL MEMBERS

1. Dr. Charles Hamilton
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee
2. Mr. Frank Holder
Hamblen County School Board
Morrison, Tennessee
3. Dr. Warren J. Huffman
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee
4. The Honorable Frank P. Lashlee
Chairman of Education Committee
Representing House District 74
Camden, Tennessee
5. Dr. O. S. Sexton
Chairman, Hamblen County School Board
Morristown, Tennessee
6. The Honorable J.B. Shockley
Representing House District 10
Morristown, Tennessee
7. Mrs. David S. Smith
Morristown City School Board
Morristown, Tennessee
8. Dr. C. Kenneth Tanner
Education, Administration, and Supervision
The University of Tennessee
Knoxville, Tennessee
9. Mr. William Thompson
Morristown City School Board
Morristown, Tennessee
10. Dr. Bill C. Wallace
Division of Health and Safety
The University of Tennessee
Knoxville, Tennessee

APPENDIX D

ADDITIONAL COMMENTS

ADDITIONAL COMMENTS

The legislators, members of the State Board of Education, and local school board chairpersons made additional written comments on their opinionnaire. These comments are copied verbatim from their opinionnaire regarding their perception toward the Tennessee secondary school health education program in terms of health content, services, and practices.

Members of the State Board of Education

"We do not do enough in the health content areas of consumerism, alcohol/drug abuse, smoking and use of tobacco products, sex education, marriage and parenting."

"Not all health content areas are applicable to all Tennessee public schools although I agree all should be taught."

"The health services statements deals only with socialistic attitudes toward what society should provide. I am opposed."

"I strongly disagree that seat belts be installed as a safety measure in school buses because the need has not been proven."

"Dieting, sex education, and marriage and parenting are not a function of education."

"Safety and health of students in school must be protected--education has no responsibility beyond the classroom."

"I believe there are viable and adequate resources for health education outside the classroom available to anyone who can read. Attempts to establish stronger and more costly programs will detract from needs with higher priority."

Local School Board Chairpersons

"Sex education is important--but it should be taught as a sterile subject--only with values added to guide it."

"Health education should include CPR and first aid taught by certified instructors."

"Driver education should be taught by local police or State highway patrol."

"Local school systems cannot afford the calibre of teachers necessary for teaching all the health content areas listed."

"Results would seem to indicate that we are not doing so well in health education."

"Health services are not responsibilities of the school but are responsibilities of the parents."

You omitted a question about free birth control information and devices. Why?"

Many of the health services are already available from other agencies."

"Students would not use seat belts on school bus."

"We don't need to assume health services that are parental duties."

"Most health services are not practical or feasible."

"Who would pay for these health services?"

"Health of the students is not a responsibility of the educational system."

Most of the health services should be under the auspices of the county health departments."

"We need State curriculum framework on all courses."

"Teachers should be required to meet certain physical fitness standards."

"Health education needs to be taught as a separate subject."

"If health education were taught as part of another subject, we would not receive much health education."

"The senior high school health classes should be two semesters in length if it is broadened beyond the regular health course."

"Some of the teaching in health could be done better by persons from the medical profession (nurses, physicians, etc.)"

Legislators

"Course and course content should be left to the discretion of local community. Too much is already being mandated by law for any already overburdened school system!"

"CPR should be included in first aid."

"As legislators, we generally do not have a good idea as to what should be included in health content."

"The school nurse could provide teacher inservice training in areas of first aid and emergency services for injury and sudden illness."

"Maybe teachers should receive physiological examinations every five years."

"Tennessee schools are not doing an adequate job in teaching health."

"I cannot respond to some of the statements because of ignorance of the subject, but I am reluctant to mandate too many subjects in too specific a manner. We have meddled too much in curriculum already."

"You are studying an area about which I do not have any expertise."

"Teachers have too much paperwork, they need to be teaching."

"There will never be enough money funded for health services, it has been continually growing."

"I am not very knowledgeable on health education matters."

"I do not have a very good background in educational legislation and education matters."

"Doctors and dentists should provide consultation and advice to schools free of charge."

"School health education could be combined with physical education."

"If physicians and dentists are retained for consultation, why not also retain optometrists, lawyers, etc."

VITA

Donnie Gene Mitchell, son of Joseph T. and Marie Shipley Mitchell, was born on May 12, 1946 in Knoxville, Tennessee. He graduated from Bearden High School of Knoxville in June 1964. In the winter of 1965 he entered East Tennessee State University, Johnson City, Tennessee, where in August 1969 he received his Bachelor of Science degree with majors in Sociology and History. In March 1971 he received a Master of Arts degree in Sociology at the East Tennessee State University. His thesis, "An Analysis of the Effects of an Early Active Intervention Program in the Rehabilitation of Cardiac Patients" was funded by the Tennessee Heart Association. While attending school he was employed as business manager for Seaton & Humphreys, Inc. for four years.

Since graduation from college, Mitchell has served as executive director of the East Tennessee Substance Abuse Council, director of the St. Mary's Memorial Hospital Alcohol Rehabilitation Program, and as the director of Alcohol and Drug Programs for Cherokee Mental Health Center. His experience in the field of alcoholism include counseling, teaching, public relations, grant writing, and program development. He designed and directed a six-county Crisis Intervention Program, an Alcohol and Drug Abuse Program, and an Alcohol Safety Program. He has written over 20 grants that have been funded by the State or federal governments.

Mitchell entered the Graduate School of The University

of Tennessee, Knoxville, in August 1975. He received the Doctor of Education degree with a major in Health Education and a collateral in Public Health Administration and Planning in June 1982.

In June 1979 Mitchell became self-employed in the field of alcohol education and rehabilitation, working in 16 counties of East Tennessee. He has compiled and published the first United States Directory of Alcohol Safety/Rehabilitation Programs.

He has actively participated in many church, community, school, and civic organizations since 1972. Mitchell is married to the former Judith Acker of Knoxville, and they have two sons, David Gregory, and Brian Christopher.

Professional memberships include American Public Health Association, Tennessee Society of Public Health Educators, American Alliance for Health, National Council on Alcoholism, and Professional Alcoholism and Drug Abuse Counselors in Tennessee and is licensed by the Tennessee Department of Mental Health as a substance abuse counselor. Mitchell has also taught part-time at East Tennessee State University and at Walters State Community College.